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REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

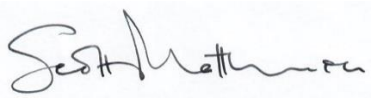
Derek Albert RUSSELL (died 28.01.21)

	THIS REPORT IS BEING SENT TO: [redacted] Chief Executive Medway Maritime Hospital Medway NHS Foundation Trust Windmill Road Gillingham Kent ME7 5NY
1.	**CORONER** I am Scott Matthewson, Assistant Coroner for the coroner area of Mid Kent & Medway.
2.	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3.	**INVESTIGATION and INQUEST** On 8 February 2021 the Area Coroner for Mid Kent & Medway, Ms Bina Patel, commenced an investigation into the death of Derek Albert Russell who died,

	aged 90, on 28 January 2021 at the Medway Maritime Hospital, Windmill Road, Gillingham, Kent ME7 5NY. The investigation concluded at the end of an inquest on 16 April 2021, conducted by me. I concluded that the deceased had died as a result of natural causes and that the medical cause of death was: Ia. COVID-19 pneumonia Ib. Ic. II. Dementia, Heart Failure, Acute on Chronic Subdural Haematoma, Fall
4.	**CIRCUMSTANCES OF THE DEATH** Mr Russell lived with his wife at their home in Chatham. He had a history of being unsteady on his feet, falling over and suffering injuries as a result. On 11 January 2021 Mr Russell was found at home having had an unwitnessed fall. He was taken to the Medway Maritime Hospital. He had a GCS score of 13/15 and was confused. A CT brain scan showed no acute pathology. Mr Russell was treated for a suspected infection with fluids and antibiotics. At about 02.00h on 12 January 2021 Mr Russell was assessed for risk of falls. He was assessed as being at “high risk” of falling and the need for a falls alarm equipment was identified. Despite numerous requests by nursing staff, no falls alarm equipment was provided to Mr Russell. By 16 January 2021 Mr Russell had still not been provided with a falls alarm due to lack of availability. At 01.45h on that date Mr Russell suffered an unwitnessed fall. A CT brain scan revealed chronic bilateral subdural haematomas. Advice was sought from a specialist brain injury team at King’s College Hospital in London and conservative treatment was recommended. After his fall a further falls assessment was conducted. The need for falls alarm equipment was identified and Mr Russell was assessed as “high risk”. Nursing staff had to take a falls alarm from another patient and give it to Mr Russell. This put the nurses in the invidious position of having to choose which patients should have the protection of this equipment.

	On 20 January 2021 Mr Russell appeared more confused and a further CT brain scan revealed interval progression of the acute left sided subdural haematoma and a new right temporo-parietal intraparenchymal haemorrhage with associated vasogenic oedema. Advice from KCH was to continue conservative treatment. Mr Russell's condition appeared to stabilise but he then developed lung crepitations and was tested for Covid-19. The test result the following day was positive. Mr Russell's condition deteriorated and he died on 27 January 2021. Mr Russell's death was due to Covid-19. It is possible that his fall and brain injury were a contributing factors but there was insufficient evidence to make that finding on the balance of probabilities.
5.	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: Evidence was given by clinical staff at the Medway Maritime Hospital (and helpful correspondence received from the Trust's lawyer after the hearing) that: (1) The reason Mr Russell was not provided with falls alarm equipment was because there was a chronic shortage of this equipment within the Medway Maritime Hospital. (2) The shortage of falls alarm equipment was a long-standing problem and pre-dated the Covid-19 pandemic. (3) The 'second wave' of Covid-19 hospitalisations had made the problem even worse than normal. (4) Whilst the risk of falling cannot be eliminated altogether, if falls alarm equipment had been available the chances of Mr Russell falling and sustaining a traumatic brain injury would have been significantly reduced. (5) Falls alarm equipment is an essential tool for nursing staff in reducing the risk of falls and related injuries because they enable staff to identify

	a patient who is about to fall and prevent it (or attend to the patient more swiftly if unable to prevent the fall in the first place). (6) The falls alarm equipment consists of: a. A 'falls alarm' which is a 'clip and cord' device that acts as a warning sign to staff that a patient is trying to move (for example, a 'SURE Monitor'); b. A 'bed sensor mat' which consists of a mat located under a patient's bedding and which is connected to a falls alarm (which alerts staff when a patient attempts to get out of their bed); and c. A 'chair sensor pad' which sits under a patient when they are sitting on a chair. It is also attached to a falls alarm and alerts staff when a patient is trying to rise from their chair. I am concerned that: (a) Patients who are assessed as requiring falls alarm equipment in future will not receive it due to chronic shortages of that equipment in the Medway Maritime Hospital. (b) By failing to provide adequate falls alarm equipment, patients are at increased risk of falling and sustaining fatal injuries (or injuries such as fractures and brain injury that that can lead to immobility, susceptibility to infection and death). (c) The ability of clinical staff to monitor and reduce the risk of patients falling and sustaining fatal injuries is seriously compromised by the lack of this basic safety equipment and is putting lives at risk.
6.	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and/or your organisation have the power to take such action.
7.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 June 2021. I, the coroner, may extend the period.

	Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8.	**COPIES and PUBLICATION** I have sent a copy of my report to the following: • HHJ Thomas Teague QC, the Chief Coroner of England & Wales • [redacted] on behalf of the family of Derek Russell I am under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9.	Signature:  Scott Matthewson, Assistant Coroner, Mid Kent & Medway 23 April 2021