	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) Chief Executive of University Hospitals Birmingham NHS Trust** **2) NHS England**
1	**CORONER** I am Mr Adam Hodson, Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 24 February 2021 I commenced an investigation into the death of Leonard Arthur PRITCHARD. The investigation concluded at the end of the inquest. The conclusion of the inquest was Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died on 18 February 2021 in Good Hope Hospital, Sutton Coldfield, as a result of injuries which he sustained following an unwitnessed fall from a chair in an A&E cubicle on 12 February 2021. He was treated conservatively, but his condition deteriorated over the course of the following days and sadly he did not recover. He was originally admitted as a precaution following an unwitnessed fall at his care home earlier on 12 February 2021, where CT scanning indicated that he did not sustain any acute intracranial injury at that time. He was subsequently assessed in the emergency department as being at a risk of falls by the nursing staff, who implemented appropriate falls prevention measures. He was not provided with a zimmer frame to allow him to mobilise, and no discussion took place between staff as to how he was to mobilise in the absence of a walking aid. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a PNEUMONIA** **1b INTRACRANIAL HAEMORRHAGE** **1c FALL** **II ATRIAL FIBRILLATION (ANTI-COAGULATED), HYPERTENSION, TYPE 2 DIABETES MELLITUS, ISCHAEMIC HEART DISEASE, DEMENTIA**
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. - 1. During the course of the inquest, I heard evidence that there is an inadequate supply of mobility aids within the emergency department of Good Hope Hospital which are utilised by the Older People Assessment and Liaison (OPAL) team when assessing patient's mobility, and which are given to patients who are identified as requiring an aid. I heard that there are

	presently 2 zimmer frames, whilst there are 17 cubicles in majors; 5 resuscitation cubicles; 6 trolleys in the new extension of the the emergency department; and 8 chairs in the clinical decision unit. I heard from staff that they consider this mobility aid to patient bed ratio was inadequate. There is a clear risk of death for patients who require mobility aids but can not have access to them. The Trust should consider addressing this as a matter of urgency. 2. Linked to 1) above, I heard evidence that procurement discussions are taking place, but from the evidence it is unclear who has overall responsibility for the assessment; selection; and procurement of aids, and neither is it clear when this process will be completed by. The Trust should consider ensuring that this procurement process takes places as a matter of urgency.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 12 August 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 Chief Coroner and to the following Interested Persons:- Family of Mr Pritchard. I am also 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	**17 June 2021** Signature: **Adam Hodson** **Assistant Coroner for Birmingham and Solihull**