REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The National Institute for Health and Care Excellence (NICE)**
1	**CORONER** I am Mrs Joanne Lees, Area Coroner for the Black Country Jurisdiction
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 18/2/21 I commenced an investigation into the death of **GEOFFREY WILLIAM HILL** aged 82. The investigation concluded at the end of the inquest on 13/5/21. The medical cause of Mr Hill's death was recorded as; 1a) Traumatic Subdural Haemorrhage The conclusion of the inquest was Accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On the morning of 4/2/21 Mr Hill, an 82-year-old gentleman was admitted to hospital with Covid-19, reduced mobility and feeling generally unwell. He arrived in the A & E department at approximately 10.13 am and was seen immediately by a medical doctor. Whilst in the emergency department and awaiting test results, at approximately 17.25. Mr Hill was witnessed to fall from the end of the trolley bed, landing on the floor hitting his head. Mr Hill was conscious but had sustained an obvious head injury. He was seen again by a Doctor and scoop stretched back onto the bed trolley to await a CT scan of his head whilst neurological observations were undertaken. His observations remained unchanged until at approximately 9 pm when Mr Hill deteriorated and became unresponsive. A CT scan identified a very large acute subdural haematoma with significant midline shift. Mr Hill's head injury was managed conservatively, and he sadly passed away in hospital in the early hours of 5/2/21. There was a delay in arranging the CT scan after the fall due to Mr Hill's Covid status, but this did not affect the outcome.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) Mr Hill remained in the A & E isolation area for over 7 hours without any falls risk assessment being conducted. He was placed on a bed trolley with the bed rails down and a call bell within reach. He was barefoot at the time of the fall. Mr Hill was not subject to any advanced observations prior to his fall. Mr Hill was noted on admission to be suffering with reduced mobility, having been 'off his legs' and was noted to be 'mildly

	confused' at times; (2) The inquest heard in evidence that there were no national guidelines on the use of falls risk assessments in A & E departments; (3) The inquest heard in evidence there was no national requirements or guidance for a trolley rail assessment to be completed in A & E; (4) As Mr Hill did not present with a fall or recurrent falls there was no requirement for any generic or multi factorial risk assessment to be conducted; (5) An investigation revealed no abbreviated mental test (AMT) had been conducted on admission to ED; (6) An investigation revealed no therapy assessment had been conducted as Mr Hill remained in the isolation area awaiting the results of further tests; (7) An investigation revealed no falls prevention information was provided to patients attending the emergency department; (7) I am concerned that vulnerable and elderly patients in A & E can spend long periods without any falls risk assessments being undertaken placing them at risk. (8) It was noted that the specific hospital concerned has decided to introduce a shortened version of the falls risk assessment in A & E along with a trolley rail assessment and has displayed a number of posters alerting staff to falls risks in A & E. These actions were welcomed by the Coroner however the Coroner invites NICE to consider introducing national guidelines for **ALL** A & E departments across England & Wales.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 30/7/21. 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 namely the Dudley Group NHS Foundation Trust and the family of Mr Hill. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**2/6/21** **Mrs Joanne M. Lees** **Area Coroner** JMLees