REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Risk Management Department, Pinderfields General Hospital, Wakefield, West Yorkshire.
1	**CORONER** I am Lorraine Harris, assistant coroner seconded to the coroner area of West Yorkshire (East) sitting in Wakefield
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 29th May 2020 I commenced an investigation into the death of Mary Ann LINCOLN. The investigation concluded at the end of the inquest on 2nd August 2021. The conclusion of the inquest was a narrative: "On 18th May 2020 Mary Ann LINCOLN was admitted to Pinderfields General Hospital. It was known that she required walking aides. The falls policy was not implemented correctly. Mrs Lincoln was placed into bed in a single occupancy room at around 2230 on 20th May 2020 and requested the bed rails be placed in the upward position. She had received a significant underdosage of her medication to treat Congestive Cardiac Failure and it is probable that this led to her needed to have an increased need for the toilet and breathlessness. She was last checked at 0240 hours on 21st May 2020. At 0630 she was discovered deceased on the floor of her room with an open fracture of her tibia and fibula. Her bed rails were still in place. It was evident that she had lain there for some time" **COD:** 1a Traumatic fracture of right tibia and fibula 2 Atrial fibrillation, pulmonary hypertension, ischaemic heart disease
4	**CIRCUMSTANCES OF THE DEATH** Narrative covers circumstances. Vulnerable lady, falls policy, medication, bed rails failings.
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) During evidence it became apparent that there is no guidance or policy with regard to checks on patients overnight (who are not subject to NEWS, turning etc). Mrs Lincoln was put in to bed at around 2130 and only checked once in the night despite being in

	hospital, having a history of falls and knowledge of the fact she needed the toilet overnight. Although she had previously used the call buzzer she was also known to mobilise herself. She was not discovered until 0630, and then only because someone noticed as they passed her door. She had lain on the floor for some time, with an open fracture. The hospital conducted a serious incident review in which it recommended the checks policy should be reviewed. It appears it was reviewed but no changes were made. Evidence had been heard that previous rounding checks were deemed inappropriate and therefore no further action was required. Therefore there is no policy or guidance with regard to people who are vulnerable, a falls risk and known to get up in the night (for any reason) to be further assessed for checks overnight. (2) There is a bedrails policy in place, the author of the SI report found that it appeared to be comprehensive. During evidence however the staff responsible for implementing its use were either unaware of it (it appears it is not circulated to HCA's), or find it confusing. There is obviously a void between producing a policy and ensuring it is circulated and understood by all concerned.
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 27th September 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 Mr [redacted], son. 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	**[DATE] 2nd August 2021 [SIGNED BY CORONER]** ***Lorraine Harris***