Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 University Hospitals Of Derby And Burton** **2 Ilkeston Community Hospital**
1	**CORONER** I am Sabyta Kaushal, Assistant Coroner, for the coroner area of Derby & Derbyshire Coroner's
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 14 September 2018 I commenced an investigation into the death of Kenneth PERKINS aged 94. The investigation concluded at the end of the inquest on 28 April 2022. The conclusion of the inquest was that: Kenneth Perkins, date of birth 25th December 1923, of 2 Middlemore Cottages Stanhope Street, Stanton By Dale had a history of recurrent falls. He had a number of co-morbidities - atrial fibrillation, diabetes, trans ischaemic attacks. He attended Royal Derby Hospital on 4th September 2018 following left sided weakness facial droop and confusion. He was agitated , remained confused and lacked capacity. A risk assessment required him to have the assistance of one carer when mobilising; despite this he was wandering in the bed area independently without assistance when he fell and hit his head. The subarachnoid bleeding could not be treated; he was treated palliatively and sadly he died at the Royal Derby Hospital on 11th September 2018.
4	**CIRCUMSTANCES OF THE DEATH** Mr Perkins was admitted to Ilkeston Community Hospital on 7th June 2018 where full risk assessments were carried out; it was established that he was at high risk of falls. He was transferred to the Royal Derby Hospital on 3rd September 2018. He fell died at the Royal Derby Hospital on 4th September 2018 and died on the 11th September 2018.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) Mr Perkins was transferred from Ilkeston Community Hospital to the Royal Derby Hospital. There was no clear detailed handover or transfer document which would have detailed his medication, medical history and history of recurrent falls The Royal Derby Hospital did not (but should have) requested a transfer document from Ilkeston. That history would have

	allowed an enhanced level of care and observation to be put in place so as to prevent further falls.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 June 23, 2022. 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 [redacted] I have also sent it to **Royal Derby Hospital** **Ilkeston Community Hospital** who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 18.10.2022** [signature]