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 **Chief Coroner - PFD Reports** 2 [redacted] 3 [redacted]
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 03 November 2020 I commenced an investigation into the death of Anthony David BLOWER aged 83. The investigation concluded at the end of the inquest on 08 December 2022. The conclusion of the inquest was that: On the 25th October 2020 Anthony David Blower died at his home address in Sussex Road, Petersfield. He had sustained a number of falls in September 2020, was admitted to hospital and diagnosed with bilateral subdural haematoma. He underwent burr hole surgery on the 26th September 2020. Mr Blower was transferred to Queen Alexandra Hospital on the 13th October 2020 and found on the floor next to his bed at 21.00 on the 14th October 2020, on the 20th and 21st October 2020 his condition declined significantly . A CT scan revealed further bleeding, Mr Blower did not undergo further surgery and received palliative care.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died following a fall which caused an initial bleed affecting his brain. He suffered from pre-existing cardiac conditions and cerebral amyloid angiopathy which may have contributed to the initial fall and the bleeds to his brain. The impact of his age and multiple medical conditions complicated his treatment and impacted recovery.
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) 1) Evidence at inquest revealed that none of the nursing care plan risk assessments, which had been completed on Mr Blower's arrival on the ward, had been updated during his stay. I heard evidence that there were changes to his clinical presentation that were recorded in the nursing notes and that these should have been reflected in updated risk assessments. The multi factorial falls risk assessment had not been fully completed on admission nor fully

	updated after an in-patient fall by Mr Blower. The evidence I heard from the nursing staff was that they are potentially missing opportunities for nursing interventions when risk assessments are not updated and that they do not always have the time to review the nursing notes. I note that the hospital is carrying out audits of documentation completion and updating some systems. However, some 2 years after the death of Mr Blower, the ward manager stated in evidence that her reviews of care plans showed a huge variety in the level of completion and that concordance with documentation remained poor. The hospital witnesses noted that staff were under significant time pressure and completing documentation is not seen as a priority. 2) Mr Blower was found to be dehydrated and he required IV fluids during his admission. The hospital nutrition policy (section entitled hydration) states that it is the responsibility of the registered nurse and medical practitioner to ensure patients receive adequate fluids and that a minimum of 7 drinks should be provided daily. In evidence I was informed that the nurses monitor fluid intake by keeping an eye on water levels in patients' jugs (for those not deemed to require fluid intake charts). There is no-one on a ward with overall responsibility for ensuring that the trust policy on hydration is adhered to. Representations from the hospital state that other members of staff also keep an eye on nutrition. This was not sufficient to prevent Mr Blower from becoming seriously dehydrated.
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 February 25, 2023. 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 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: 31/12/2022**  **Robert SIMPSON** **Assistant Coroner for** **Hampshire, Portsmouth and Southampton**