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. [redacted] CEO, Essex Partnership NHS Foundation Trust**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 23 October 2020 an investigation was commenced into the death of Doris Joyce SMITH, aged 74 years. Doris Joyce Smith died on the 14 October 2020. The investigation concluded at the end of the 5-day inquest on 27 January 2023. The conclusion of the inquest was Narrative with a medical cause of death of 'Ia Head Injury Ib Fall, II Dementia, Frailty, Coronary Atherosclerosis'.
4	**CIRCUMSTANCES OF THE DEATH** Doris Joyce Smith had a fall on Ruby Ward on 9 October 2020. As a consequence she suffered a head injury and was taken to Broomfield General Hospital. Subsequently she was diagnosed with a subarachnoid haemorrhage and after consultation with Addenbrookes, it was confirmed that her injury was not operable and not survivable. Doris Smith was placed on an end-of-life care pathway care plan and passed away on 14 October 2020. The falls risk assessment was only completed 12 days after Doris's admission onto Ruby Ward. Under policy guidelines and procedures it should have been completed within 24 hours after admission by the nurse. It was finally completed by a senior healthcare assistant instead but had an incomplete medical history. Subsequent errors and omissions with regard to the updates of the falls risk assessment - No evidence of the physiotherapist's advice of close monitoring during mobilsation being implemented by staff - Confusion regarding observation levels e.g 1,2 or 3 and inadequate frequency of both neurological and ward observations.

	Doris Joyce Smith died as a direct result of the fall on Ruby Ward on the 9th October 2020. Had Mrs Smith been observed and monitored as she should have been, the fall on 9th October 2020 would either have been avoided or there would have been a staff member present to break her fall. Had the fall been broken, it is likely that Mrs Smith would have avoided injury, or her injuries would have been less severe. The fall suffered by Mrs Smith on 9 th October 2020 caused her to suffer a traumatic subarachnoid haemorrhage, which led to her death on 14th October 2020. In addition, the falls risk assessment and the level of observations were inadequate. There is no evidence of effective communication between the different professionals as to the correct care Doris Smith should be receiving. As well as the lack of implementation of correct and accurate record keeping. Evidence heard as to inconsistencies between staff on Ruby Ward as to which were the correct levels of observations, especially following the falls on the 1 st , 8th and 9th October 2020. All of these factors led to the incorrect observation of Doris Smith which contributed to the circumstances leading to her death
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) Essex Partnership NHS Foundation Trust staff: a. delayed the completion of a falls risk assessment b. completed the falls risk assessment with inaccurate information to assess Doris Smith's risk and updates were also inaccurate c. did not follow the advice of the physiotherapist that would have required Doris Smith to mobilise only with assistance of staff and whether her level of observations should have been changed. (2) Neurological observations following a sustained head injury were not completed as required (3) Doris Smith had falls on the ward and her level of observations was not reconsidered in light of advice from the physiotherapist after each fall. (4) The Trust Observation Policy is used in different therapeutic settings and is confusing as to the Levels of Observation required and the focus is on risk for mental health rather then physical healthcare issues that may arise. (5) Quality of record keeping:

	a. The Trust medical records recording system is electronic and evidence was heard that the window on the screen used for staff to type their records is very small and difficult to use. b. There were significant examples of cut and paste including out-of-date information recorded in the medical records. (6) Lack of effective communication as to the care and treatment required for Doris Smith between Trust staff and the levels of observations required to keep her safe on the ward
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Monday 24 April 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] (Son) • Care Quality Commission 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	 **27.02.2023** **HM Area Coroner for Essex Sonia Hayes**