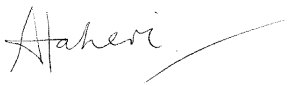
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 The Right Honourable Steve Barclay MP** **Secretary of State for Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU** **2 Mrs Amanda Pritchard** **Chief Executive for NHS England** **PO Box 16738** **Redditch** **B97 9PT**
1	**CORONER** I am Peter TAHERI, Assistant Coroner for the coroner area of Suffolk
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 18th March 2022 an investigation was commenced into the death of Joseph Willy Maunick. The investigation concluded at the end of the inquest on 18th April 2023. The narrative conclusion of the inquest was that: **Joseph Willy Maunick (Will) died on 15th March 2022 as a result of a severe head injury that he suffered in a fall in the Emergency Department of West Suffolk Hospital on 4th March 2022. He was in the Emergency Department as a social admission, while his wife was going through unplanned emergency major surgery.** **Will was not safe to be left alone at home and required care around the clock. Exhaustive efforts to find appropriate care while his wife was in hospital were unsuccessful, so he had been admitted to a hospital Emergency Department as a last resort. This was not the most suitable environment for a gentleman with dementia who was a falls risk and required constant supervision. The situation was exacerbated by pre-existing severe pressures on the Emergency Department on that day due to high demand for beds, without the availability of beds to meet the demand, and a severe deficiency of staff. The scarcity of resource, relative to demand, at the hospital also contributed to Will not being transferred to a ward sooner. While there was no specific failure by an individual that contributed to the death, Will's death was contributed to by the lack of availability of more appropriate care.** The medical cause of death was confirmed as: **1(a) Subdural Haematoma**

	1(b) Fall **2 Dementia, Complete Heart Block, Frailty**
4	**CIRCUMSTANCES OF THE DEATH** Joseph Willy Maunick (Will) was an intelligent man, gifted with communication skills, who worked as a teacher and spoke multiple languages. In his later years he developed cognitive impairment, which in turn led to him being at very high risk of falls. This risk, in relation to which he needed constant supervision, was known to those caring for him and to those responsible for looking after him when he was admitted to the Emergency Department of the West Suffolk Hospital on 4th March 2022. He was admitted to the hospital Emergency Department not because he himself was experiencing a medical emergency, but as a last resort after exhaustive efforts to explore all options before Will was admitted to hospital: it proved not to be possible to find suitable alternative care for him in residential care placements while his wife, and main carer, underwent unplanned emergency major surgery. The inquest heard evidence that, prior to his admission to hospital, at least eight social care providers were contacted plus further residential homes, but none of them could provide emergency care for Will. The inquest heard undisputed evidence that this was an instance of a national care shortage. The inquest heard evidence that in an Emergency Department where many patients are suffering medical emergencies constant one-to-one supervision will not always be possible. I found as a fact that it was not possible on this occasion and that Will's fall in the Emergency Department took place when the nursing assistant who was trying to maintain constant one-to-one supervision of Will insofar as possible had their attention momentarily diverted to another patient experiencing a medical emergency. I judged that it would not be just to describe this as a failure on the part of the nursing assistant or the Emergency Department staff. The reason why it was not an individual failure included that the inquest heard evidence that the hospital, and in particular the Emergency Department, was experiencing significant pressures associated with high demand and an internal critical incident had been declared. There was a high demand for beds within the hospital without the availability of beds to meet the demand. This included the facts that there were, at the time of Will's arrival in the Emergency Department, 50 patients in the Emergency Department, of whom 32 were waiting for bed placement. Moreover, staffing was at a 'black status' (the worst level) across the hospital, with a deficiency of staff of around 60 nurses and nursing assistants. I found as a fact that those severe pressures – the high demand levels and the deficiency of staff and scarcity of resource – contributed to the death. Firstly, if it had been possible to care for and supervise Will on a constant basis as he needed, then on the balance of probabilities the fall that led directly to his passing would have been prevented and his life would have been prolonged. Secondly, on the balance of probabilities, the scarcity of resource relative to demand contributed to Will not being transferred to a ward – or other more appropriate environment – sooner. Apart from the inherent particular difficulties in providing constant supervision in an Emergency Department referred to above, the inquest also received undisputed evidence that the environment of a busy, noisy Emergency Department, with lights on at all hours of the day and night would be overly stimulating and not the most suitable environment for someone with cognitive impairment who was experiencing confusion and agitation. I found that such an environment probably contributed to Will's inclination to wander and so to his fall. If it had been possible to transfer Will to a more suitable environment sooner, then on the

	balance of probabilities the fall that led directly to his passing would have been prevented and his life would have been prolonged. I found as a fact that, on the balance of probabilities, the lack of availability of more appropriate care contributed to the death.
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) A national care shortage contributed to a situation where a gentleman who was not experiencing a medical emergency, but who required constant supervision for his own safety in view of his cognitive impairment and very high falls risk, could not be cared for anywhere other than in a hospital Emergency Department. If there is not sufficient provision of care, including residential care placements, such that those in similar need do not receive suitable care, then circumstances creating a risk of future deaths will occur or continue to exist in the future, when they are placed in an environment that is not realistically able to provide the constant supervision needed, as occurred in this case. 2) The severe pressures on the hospital, including the Emergency Department, were such that they were experiencing scarcity of resource relative to demand and a severe deficiency of staff. In these circumstances, it was both not possible to provide the care and supervision that Will needed in the Emergency Department, and the scarcity of resource contributed to Will not being transferred sooner to a ward or other more appropriate environment, where Will could receive the constant supervision that would probably have prevented the fall that led to his death. The evidence was that the scarcity of resource experienced was a challenge on the national level, rather than just a particular local issue. If hospitals, including Emergency Departments, do not receive sufficient resource, then circumstances creating a risk of future deaths, due to an inability to provide the required care and / or prompt transfer to an available ward bed or appropriate alternative place, will occur or continue to exist in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe each of you and / or your organisations 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 15 June 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] - West Suffolk NHS Foundation Trust - Norfolk County Council - Norfolk & Suffolk NHS Foundation Trust

	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	**Dated: 20/04/2023**  **Peter TAHERI** **Assistant Coroner for** **Suffolk**