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:** **The Secretary of State for Health and Social Care:** [redacted] **The Department of Health and Social Care** [redacted]
1	**CORONER** I am JACQUELINE LAKE, Senior Coroner for the coroner area of Norfolk
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 28 March 2023 I commenced an investigation into the death of Pauline SPEDDING aged 69. The investigation concluded at the end of the inquest on 08 July 2024. **The medical cause of death was:** 1a) Acute Left Subdural Haematoma 1b) Fall 1c) 2) Type 2 Diabetes Mellitus, Postural Hypotension, Chronic Kidney Disease, Aortic Stenosis, Frailty, Extended-Spectrum Beta-Lactamase Escherichia Coli Urinary Tract Infection **The conclusion of the inquest was:** Accident
4	**CIRCUMSTANCES OF THE DEATH** Mrs Spedding had a complex medical history and a history of falls and was frequently admitted to hospital as a result. Mrs Spedding was admitted to Norfolk and Norwich University Hospital from 11 to 15 February 2023 and again from 18 February to 6 March 2023 due to falls. On 7 March 2023 Mrs Spedding had a further fall at home and was admitted to Norfolk and Norwich University Hospital. There were deemed to be multifactorial reasons for her falls and she was identified as at high risk of falls. Consideration was being given to discharging Mrs Spedding when she had an unwitnessed fall in the bathroom on 13 March 2023. She was examined and no concerns were raised regarding injury. On 17 March 2023 Mrs Spedding was found lying on the floor by the sink in the bay. She was examined and no significant injury was found. On 18 March 2023 Mrs Spedding was moved to Gunthorpe Home First Unit which cares for patients medically fit for discharge and awaiting input into care needs. It aims to encourage independence and encourages movement. On 20 March 2023 Mrs Spedding was positive for Escherichia coli and she was moved to a side room. The risk of infection was not documented alongside her high risk of falls. The Falls Response Team was not notified. On 24 March 2023 at 00.20 Mrs Spedding was found on the floor next to her bed and had a graze to her elbow.

	At 03.30 hours Mrs Spedding was found sitting on the floor next to her bed. She declined observations. Mrs Spedding was reviewed by a doctor at 04.55 and a CT scan was requested Mrs Spedding became increasingly unresponsive and she suffered a pericardiac arrest. The CT scan showed a large subdural haematoma. Mrs Spedding's condition continued to deteriorate, and she died later that morning. Throughout her stay falls risk assessment documentation, care plan documentation and hot debrief documents were not completed or not completed in full. Mrs Spedding was not referred to the Falls Response Team.
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: 1. Consideration was being given to discharging Mrs Spedding from hospital from on or about 13 March 2023 and steps were being taken to find a suitable placement for her. 2. Mrs Spedding was moved between five wards during her inpatient stay between 7 March 2023 and her death on 24 March 2023, resulting in breaks in the continuity of care for Mrs Spedding and the requirement for more risk assessments to be carried out and documentation to be completed by staff. 3. The reason for the number of moves between wards was given as being due to excess beds being required in hospital over and above those which would usually be expected, as a result of difficulties with the number of patients being admitted and those able to be discharged. 4. Evidence was heard that corridors are being used to accommodate patients and seven beds are being placed in wards intended for six beds. These additional beds are referred to as "escalation beds". 5. Evidence was heard that in 2023 there were 44 escalation beds in use and for June 2024 there were 66 escalation beds in use. During the winter of 2023/2024 the number of escalation beds rose to 120. The Falls Prevention and Management Lead for the hospital referred to the elderly population in Norfolk and life expectancy being lower with resultant health issues in many parts of the county and felt it unlikely that the hospital would not need escalation beds in the foreseeable future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 September 11, 2024. 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]

	[redacted] Norfolk and Norwich University Hospital, Legal Department, [redacted] I have also sent it to: Department of Health Care Quality Commission HSIB Healthwatch NHS England (NHS Improvement) 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: 17/07/2024** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** [redacted]