H G Mark Bricknell
Senior Coroner
for County of Herefordshire

19th July 2024

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive, Hereford County Hospital
1	**CORONER** I am Hugh Gregory Mark Bricknell, Senior Coroner for County of Herefordshire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 10th May 2023 I commenced an investigation into the death of Rita HOWELLS. The investigation concluded at the end of the inquest on 10th July 2024. The conclusion of the inquest was Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** Rita Howells was transferred to Bromyard Hospital on 6th March 2023 for rehab and discharge planning. She became confused and agitated around 17th March 2023. She was found to have a low grade fever and a raised CRP. She was treated with antibiotics to cover for a possible chest or urine infection. A CT head was requested as she had a fall from bed whilst on the ward. Rita Howells generally used a call bell but on the day she fell it was found not to be working. Staff were aware. She had the CT scan on 23rd March 2023 which showed 'acute cerebral haemorrhagic contusions at the right frontal lobe and also at the base of the frontal lobes on either side of the midline' She was transferred to A&E that day and after discussion with the neurosurgical team it was deemed that this was to be treated conservatively. She deteriorated and following discussion with the family a palliative approach was implemented. Cause of death: 1a. Intracerebral Haemorrhage

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) Contrary to Policy as advised, bed rails are routinely erected before Falls Assessment (2) The procedures to establish whether a call bell is working are unsatisfactory
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, [redacted] 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 13th September 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. 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	19th July 2024 Signature HG Mark Bricknell, HM Senior Coroner: Herefordshire