	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: University Hospitals Birmingham**
1	**CORONER** I am Mr Adam Hodson, Assistant Coroner for Birmingham and Solihull
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 11 April 2024 I commenced an investigation into the death of Alan Stanley FALLOWS. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Death due to natural causes, contributed to by injuries sustained from an in-patient fall whilst in hospital
4	**CIRCUMSTANCES OF THE DEATH** **Mr Fallows was admitted into Good Hope Hospital in Birmingham on 08/02/2024 following a fall at home and was diagnosed as having sustained a suspected broken elbow as well as having postural hypotension. He was initially discharged but readmitted on 09/02/2024 due to a CT scan showing a chronic subdural haematoma. On 10/02/2024 a falls assessment was incorrectly completed but which still deemed him to be at high risk of falls, and on 12/02/2024 bed rails were put in place following an assessment. Later that day he had an unwitnessed fall but did not sustain injuries. His falls risk assessment was not updated following this fall, although his bed rails assessment was updated three days later on 15/02/2024. On 16/02/2024, he had a further unwitnessed fall and suffered a minor head injury and a fracture to his right neck of femur. On 17/02/2024 he was transported to Birmingham Heartlands Hospital for surgery which was uneventful. On 02/03/2024, he was transferred to Solihull Hospital for physiotherapy, but subsequently developed severe bilateral aspiration pneumonia. Despite optimal treatment, his condition deteriorated over the course of three weeks, and he sadly died on 28/03/2024. Although gaps in care were identified, it is impossible to say whether his falls could have been prevented.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Aspiration pneumonia** **1b Frailty of old age** **1c** **II Fracture right neck of femur (operated), Chronic obstructive pulmonary disease**
5	**<u>CORONER'S CONCERNS</u>** 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. Firstly, I have heard that the Datix report for Mr Fallows' first fall on 12 February was not completed at the time by staff, and the nurse in question is now retired and thus it was not possible to ascertain why it had not been completed. The report was only completed retrospectively two months later by staff once an inquest had been opened and a request for evidence was sent to the Trust. A Datix is a risk management information system which gathers information on processes and errors and allows staff to report on any issue which may compromise patient safety, which is central to good clinical governance and best practice, as well as contributing to learning. Whilst the failure to create the DATIX here could be a one-off, I am concerned that staff may not be aware of the importance of completing these reports and doing so in a timely fashion, which I understand should be completed within 24 hours of incident or knowledge of an incident. It is not difficult to see that where incidents are not being logged and reviewed, patient safety could be compromised, and future deaths could occur as a consequence; 2. Secondly, I was concerned to read that the Datix relating to the fall of 12 February (code U454194) appears to have undergone some kind of automated approval and sign off process in June 2024, and regrettably staff were unable to shed any light during the inquest on what happened/happens during this process. This is in contrast to the Datix relating to the second fall (code U441480) which appears to have gone through a “manual” approval and sign off process and the matter closed on 06/06/20204 (with the name of the approver being redacted on the form). I am concerned that if the Trust has any kind of automation process for the review and approval of Datix reports, there may be missed opportunities for humans to correctly identify any incident that compromises patient safety and which give rise to a risk of death; 3. Thirdly, I was concerned to hear from Senior Ward Sister [redacted] that nursing staff utilise templates or pro-forma text when completing DATIX reports. The use of templates, whilst time saving, can easily lead to incorrect or incomplete information being provided on incidents (as happened in Mr Fallows' care) and therefore there is a real risk that opportunities will be lost to correctly investigate incidents which affect patient safety and which may cause a risk of death.
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 14 October 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: The family of Mr Fallows

	I have also sent it to the Medical Examiner, ICS, NHS England, CQC, who may find it useful or of interest. 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	**19 August 2024**  Signature: **Adam Hodson** **Assistant Coroner for Birmingham and Solihull**