	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Louise Hunt, Senior 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 4 July 2024 I commenced an investigation into the death of Robert TAYLOR. The investigation concluded at the end of the Inquest. The conclusion of the inquest was; Natural causes contributed to by injuries sustained in a fall when he was not receiving enhanced nursing observations.
4	**CIRCUMSTANCES OF THE DEATH** Mr Taylor suffered from prostate cancer was frail and had chronic liver disease. On 29/05/24 he fell in the bathroom at his home address after his leg gave way. He was admitted to Birmingham Heartlands Hospital where he was investigated and treated for pancytopenia, possible infection and dropping HB. He was being nursed in a side room due to the increased risk of infection. In the morning on 11/06/24 he was noted to be very confused and agitated and it was recognised that he required enhanced 1:1 observations. No enhanced observations were put in place. He did have non slip socks and the bed rails were down to reduce the risk of him falling. He received lorazepam to enable a CT scan to be undertaken at 11.06. At around 18.13 he was found face down in his side room with an obvious head injury. A CT scan confirmed bilateral subdural haematomas and a small subarachnoid haemorrhage which were treated conservatively. A bone marrow biopsy confirmed he was sadly suffering from high grade acute myeloid leukaemia and inflammatory markers showed this disease was progressing. He continued to deteriorate and sadly passed away on 21/06/24. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a High grade Acute Myeloid Leukaemia 1b 1c 1d II Acute subdural and subarachnoid haemorrhage (traumatic)

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** is as follows. – 1. The central issue in this case relating to the fall on 11/06/24 was the lack of enhanced nursing observations. The Nursing witness was unable to say what steps, if any, had been taken to try to put enhanced observations in place. The Investigation report stated that enhanced observations had been identified as needed but did not expand on what actions were taken, if any, to obtain enhanced observation nor what actions had been taken after the death to ensure enhanced observations for patients that require them. This raises a concern for future deaths. 2. The witnesses and the investigation report did not address the central issue relating to the fall and this raises a concern about the quality of post death investigations being undertaken by the Trust. This raises a concern for future deaths.
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 17 December 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: Mr Taylor's Family I have also sent it to the Medical Examiner, ICS, NHS England, CQC. 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	**22 October 2024** Signature: **Louise Hunt** **Senior Coroner for Birmingham and Solihull**