Report to Prevent Future Deaths
Carl Edmond EASTMAN (Date of death: 28 July 2024)

	Regulation 28 Report to Prevent Future Deaths
	THIS REPORT IS BEING SENT TO: The Chief Executive Officer Royal Free London NHS Foundation Trust Anne Bryans House 77 Fleet Road London NW3 2QG
1.	**CORONER** I am Ian Potter, assistant coroner for Inner North London.
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 1 August 2024, an investigation was commenced into the death of Carl Edmond EASTMAN, aged 96 years at the time of his death. The investigation concluded at the end of an inquest heard by me on 17 December 2024 and 5 February 2025 at St Pancras Coroner's Court. The conclusion of the inquest was 'accident'. The medical cause of death was: 1a traumatic right extra-axial haemorrhage 1b anti-coagulation treatment 1c pulmonary embolus (2018, 2022) II metastatic prostate cancer
4.	**CIRCUMSTANCES OF DEATH** Carl Eastman was admitted to the Royal Free Hospital on 23 July 2024, following a fall at home, which was subsequently found not to have caused any injury. He was admitted to a ward where, on 25 July 2024, he had an unwitnessed fall, which did not result in any significant injury. As a result of this fall, Mr Eastman was transferred to an 'Enhanced Care Bay' to reduce the risk of further falls, where he should have been kept under constant observation.

	In the early hours of 28 July 2024, Mr Eastman had a second unwitnessed fall at a time when a member of staff should have accompanied him. Following this, staff did not follow practices and procedures in place for patients sustaining falls and there was, at times, a total lack of communication between staff. Mr Eastman was found to have an irreversible bleed on the brain as a result of his fall on 28 July 2024. Mr Eastman died in hospital on the evening of 28 July 2024, as a direct result of the injury sustained in the unwitnessed fall in the ward earlier that day.
5.	**CORONER'S CONCERNS** During the course of my investigation and the inquest, the evidence revealed matters giving rise to concerns. 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. I heard evidence from both a consultant geriatrician and the head of nursing for the AMEDEC division. I was provided with an action plan from the Trust, which sets out numerous measures that the Trust has already put in place or plans to put in place. The concerns I am bringing to your attention by way of this report, relate to matters that do not appear, as yet, to have been considered by the Trust. The **MATTERS OF CONCERN** are, as follows: 1. The consultant geriatrician's evidence was that CT scan was requested to take place 'as soon as possible' following the first unwitnessed fall on 25 July 2024; however, they accepted that this was not conducted in a timely manner. Further, following the second unwitnessed fall on 28 July 2024, there was a further delay in a CT scan taking place. I was told that this scan should have been conducted within 1-2 hours of the request being made, yet it took place over three hours after the patient was reviewed by the doctor and the request for the scan was made. In Mr Eastman's case, the delays in receiving the scans transpired to be immaterial in the particular circumstances. However, I am concerned that if delays in such scans, where traumatic injury is suspected, are repeated in the future, there is a risk that deaths could occur. 2. There was evidence of what I considered to be 'widespread communication issues' in the care provided to Mr Eastman. These included: • When the on-call doctor attended to review Mr Eastman at approximately 02:45 on 28 July 2024, ward staff (incorrectly) told the doctor that nobody had fallen on the ward, which lead to the doctor leaving the ward without Mr Eastman having been

	reviewed. As the consultant geriatrician said in his evidence, communication between the ward staff and medical staff was not good. • The evidence revealed that there were deficiencies in basic record keeping. 3. As set out above, there was clear evidence that the Trust has put extensive measures in place to address the issue of staff having not followed the Trust's own post-fall procedures and protocols. However, I am concerned that the issue may not be limited to just those particular protocols and may be indicative of a wider skills/knowledge deficit. 4. Following on from the matter set out in paragraph 3 above, the evidence revealed a lack of professional curiosity on the part of some staff members (nursing and medical). In my view, this could also be indicative of an underlying skills/knowledge deficit.
6.	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 April 2025. 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 this report to the Chief Coroner and to the following persons: • Mr Eastman's family; and • The Care Quality Commission. 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 summary form. She may send a copy of this report to any person who she 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.	**Ian Potter** HM Assistant Coroner, Inner North London 17 February 2025