REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Epsom and St. Helier University Hospitals NHS Trust
1	**CORONER** I am John Taylor, Assistant Coroner for South London Coroner's Court.
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 4 October 2024, an investigation was commenced into the death of Anthony Haydn WOOD. The investigation concluded at the end of the inquest. The conclusion of the inquest was: "Accident, to which inadequate safety measures (to guard against the risk of a fall from bed) contributed". **The medical cause of death** 1a Intracranial Haemorrhage 1b Inpatient fall
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to St. Helier Hospital on 1 September 2024. On 22 September 2024, he was to be changed and turned by the ward HCA. Whilst waiting for a second nurse / HCA to join, that HCA lowered the first bed-rail. The patient rolled towards the side of the bed and fell out onto the floor. He hit his head, and his left shoulder and hip. A CT scan of the head revealed contusion, a traumatic subarachnoid haemorrhage and an acute-on-chronic subdural haemorrhage. He was not suitable for neurosurgical intervention. He died, at the hospital, on 26 September 2024.

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) the patient was identified as at high risk of a fall (2) he was deemed to be severely frail (and hence at corresponding risk, if a fall were to occur) (3) there were no crash mats at the side of his bed (4) it was known that the patient had a propensity to push staff when being changed (5) the bed-rail was not up when the patient was attended by a HCA acting alone (6) that HCA was unable, on his own, to hold on to the patient, in order to prevent him from falling out of bed (7) the patient should have had the assistance of two members of staff, and not just one, when being prepared to be washed and changed All of these matters are recorded in the Trust's own Datix report.
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 29 July 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 my report to the Chief Coroner, and to the following Interested Person: [redacted] (son of the deceased). 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	**3 June 2025** **John Taylor**