Regulation 28: Prevention of Future Deaths report

Agostino COSTA (died 12.05.13)

	THIS REPORT IS BEING SENT TO: **1. Dr Yi Mien Koh** **Chief Executive** **The Whittington Hospital NHS Trust** **Magdala Avenue** **London N19 5NF**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 12 May 2013, one of my predecessor coroners, Sean McGovern, commenced an investigation into the death of Agostino Costa, aged 80. I concluded this investigation at the end of the inquest on 28 November 2013.
4	**CIRCUMSTANCES OF THE DEATH** I concluded that Mr Costa died as a consequence of a terminal disease, though his death was hastened by an accidental fall in hospital at 6.40pm on Sunday, 12 May 2013. I recorded a medical cause of death of: 1a acute on chronic subdural haemorrhage 1b minor trauma in an individual with chronic idiopathic myelofibrosis.

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. There was confusion among the staff as to whether Mr Costa was classified as red (high risk) or green (low risk) in terms of falls. 2. There was confusion among the staff as to whether a patient walking with a frame presents a high risk of falls. 3. There was confusion among the staff as to whether a patient with myelofibrosis and blood transfusions presents a high risk of falls. This confusion was also present in the hospital root cause analysis conducted after Mr Costa's death. 4. The junior doctor present did not know how to deal with a patient post fall on the ward, though he had dealt with patients in the emergency unit who had fallen in the community. He had not attended the hospital training seminar on falls. 5. The hospital root cause analysis was not shared with all relevant members of staff, though it was signed off at the beginning of August. Thus learning points from it were completely lost to some. I heard that a great deal of work is being done in your trust to attempt to prevent falls and appropriately to treat patients when falls have occurred, but attendance at one of the monthly seminars run by the lead doctor for falls is not mandatory for all staff.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and your trust 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 28 January 2014. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] son of Agostino Costa 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 03.12.13