ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Head of Patient Safety, North Middlesex University Hospital NHS Trust**
1	**CORONER** I am Gail Elliman, Assistant Coroner, for the Coroner area of 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 23 April 2013 I commenced an investigation into the death of John William Wright. The investigation concluded at the end of the inquest on 4 October 2013. The findings at the inquest were that the medical cause of death was bronchopneumonia, caused by or as a result of Chronic Obstructive Pulmonary Disease (COPD) and a fractured spine and left humerus and the conclusion as to his death was that he died as the result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Mr Wright had a history of paranoid schizophrenia and COPD but in February 2013 his mental health appeared stable. He lived in sheltered accommodation and was admitted to the North Middlesex Hospital on 28 February with pneumonia. Despite precautions such as side bars on his bed, he had a fall from his bed that same day with no apparent adverse effects and a further fall at around 8am on 1 March 2013. At around 9:30am on 1 March 2013 he fell in the corridor but the exact cause of the fall was not clear as it was only barely observed by the doctor who was passing. There was no obvious cause and the only observation was that his pyjama trousers were 'round his knees'. It was noted that he had a left shoulder deformity, an open fracture of the humerus but no obvious head injury. He was stabilised and taken to the Intensive Care Unit and then transferred to the Royal London Hospital where he was treated conservatively. He suffered recurrent chest infections from which he died on 15 April 2013 at 18:45.
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. There was no investigation of the cause or potential cause of the fall (whether there were any external factors involved – water on the floor, over-cleaning or any other high risk matter) so as to ensure that further falls could be prevented if necessary. Even if it transpired that the cause could not be determined, the fall should have been treated as a Serious Untoward Incident that warranted some kind of investigation. The North Middlesex University Hospital NHS Trust Serious Incident Policy defines as 'serious' an 'Accident while in hospital' and I consider that such a fall should be considered to be an accident. The policy then details actions that should be taken by staff dependent on the urgency of the incident and the evidence that I was given confirmed that the appropriate electronic records were not made following the incident. 2. It was not at all clear from the evidence whether the training on falls policy and the protocols related to the recording of witnessed falls extended to the doctors as well as nurses and it is clear that, as a fall may be witnessed by any staff member at a hospital, the proper protocols should at least be known even if access to electronic means of recording an incident is limited for reasons of confidentiality.
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 26 December (or the nearest working day thereafter). 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 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	**Ms G. Elliman** **Assistant Coroner** **Inner North London** **31 OCTOBER 2013**