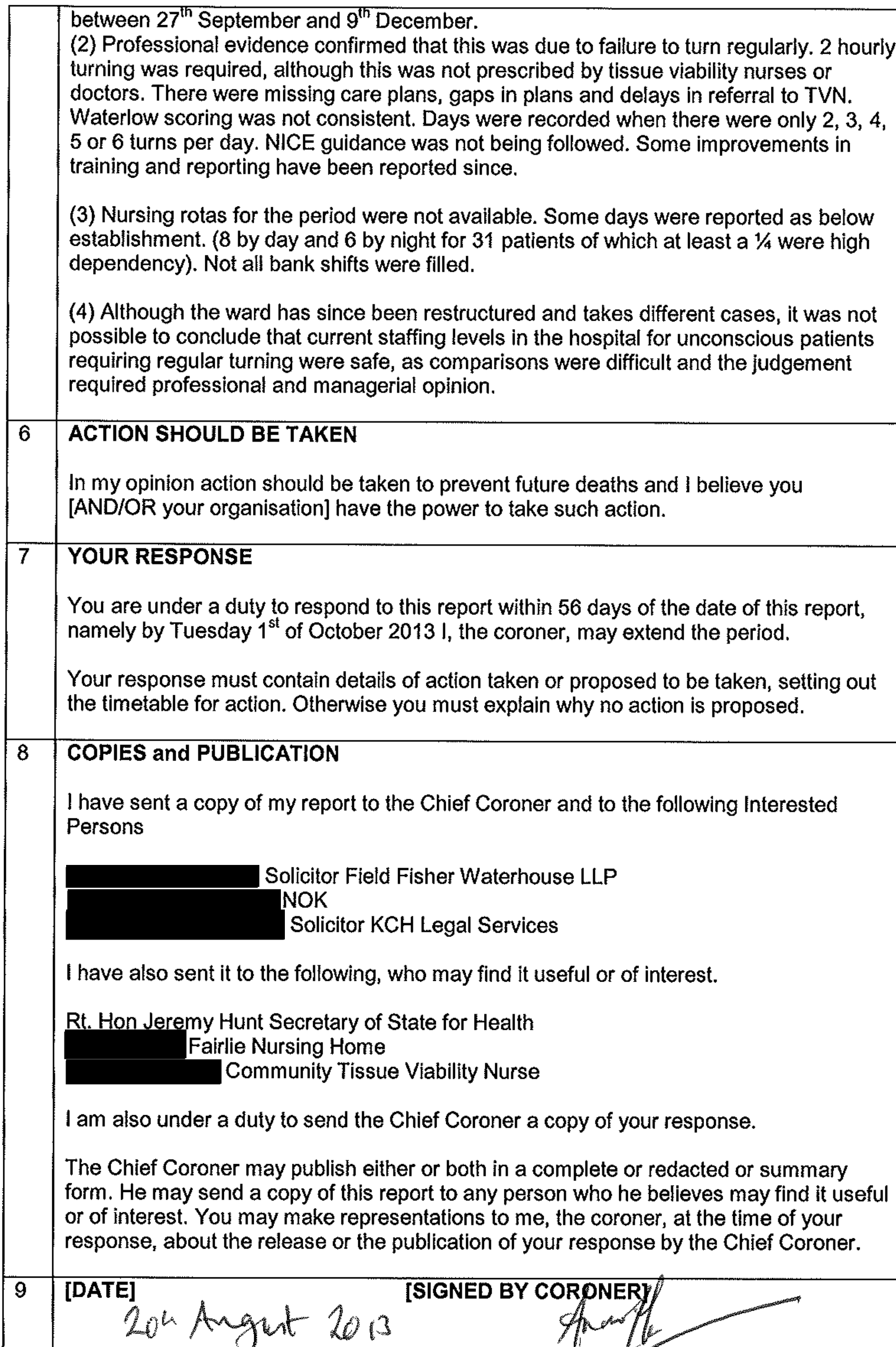
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)
*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **Re: Mohammed Mozammel Hussain CHAUDHURY, Dod: 10th July 2010, Case number: 1774-10** **Case Officer: [redacted] and Tel no. [redacted]** **THIS REPORT IS BEING SENT TO:** 1. **Mr Tim Smart, Chief Executive, King's College Hospital NHS Foundations Trust** 2. **[redacted] Deputy Director of Operations, Care Quality Commission** 3. **Sir Mike Richards, Chief Inspector of Hospitals**
1	**CORONER** I am Andrew Harris, senior coroner for London Inner South
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 10th July 2010 I opened an inquest into the death of Mohammed Mozammel Chaudhury. The investigation concluded at the end of the inquest on 2nd August 2013. The medical cause of death was 1a Overwhelming sepsis 1b Chest and other infection 1c Traumatic brain injury. The conclusion of the inquest was a narrative determination.
4	**CIRCUMSTANCES OF THE DEATH** Mohammed Chaudhury suffered multiple injuries from a traffic collision on 7th September 2009. He was cared for in Kings College Hospital initially in ITU when he was immobile due to fractured pelvis and was at high risk of bed sores due to minimal consciousness, peripheral vascular disease, diabetes and PEG feeding. He was transferred to a step down ward without pressure sores on 27th September. There he developed a number of infected pressure sores, which were due to not being nursed on an air mattress for three weeks and insufficient turning due to shortage of nursing staff. He was transferred to a nursing home with five pressure sores between grades 2 and 4, which were septic.
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) Infected pressure sores may have been a cause of death and they were unusual in extent and severity. Their development was prevented in ITU when he was most at risk and considerable improvement was achieved in the nursing home after discharge. Their development and deterioration related to nursing care on Murray Falconer ward in KCH



	between 27th September and 9th December. (2) Professional evidence confirmed that this was due to failure to turn regularly. 2 hourly turning was required, although this was not prescribed by tissue viability nurses or doctors. There were missing care plans, gaps in plans and delays in referral to TVN. Waterlow scoring was not consistent. Days were recorded when there were only 2, 3, 4, 5 or 6 turns per day. NICE guidance was not being followed. Some improvements in training and reporting have been reported since. (3) Nursing rotas for the period were not available. Some days were reported as below establishment. (8 by day and 6 by night for 31 patients of which at least a ¼ were high dependency). Not all bank shifts were filled. (4) Although the ward has since been restructured and takes different cases, it was not possible to conclude that current staffing levels in the hospital for unconscious patients requiring regular turning were safe, as comparisons were difficult and the judgement required professional and managerial opinion.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 Tuesday 1st of October 2013 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 Solicitor Field Fisher Waterhouse LLP NOK Solicitor KCH Legal Services I have also sent it to the following, who may find it useful or of interest. Rt. Hon Jeremy Hunt Secretary of State for Health Fairlie Nursing Home Community Tissue Viability Nurse 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	**[DATE]** 20th August 2013 **[SIGNED BY CORONER]**