Regulation 28: Prevention of Future Deaths report

Irshad ALI (died 07.05.14)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **Barts Health** **Royal London Hospital** **Whitechapel Road** **London E1 1BB**
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 8 May 2014, I commenced an investigation into the death of Irshad Ali, aged 79 years. The investigation concluded at the end of the inquest on 27 August 2014. I made a determination at inquest that death was caused by an accident, when Mr Ali fell in the Royal London Hospital in the early hours of 25 March 2014 and hit his head, at the time suffering severe liver cirrhosis. His medical cause of death was: 1a bronchopneumonia 1b traumatic intracranial haemorrhage 2 end stage non alcoholic steatohepatitis cirrhosis

4	**CIRCUMSTANCES OF THE DEATH** Mr Ali was admitted to hospital on for drainage of ascites. He was found on the floor of the ward at 4am on the morning of 25 March, having apparently sustained an unwitnessed fall. He left the hospital at lunch time, under the impression that he had been discharged. He later re-presented to the emergency unit, and was diagnosed with a massive head injury. In view of his end stage liver disease, surgery was not advised. He died six weeks later of a consequent chest infection.
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. The nursing staff should have checked on Mr Ali every two hours through the night, but there was no record of intentional rounding on 24/25 March. There was a record of the night before and a record of the night after, but not the night that Mr Ali fell. The chart appears to have gone missing. 2. Though the senior sister looking after Mr Ali on the morning of 25 March assured me that neurological observations were carried out hourly after his fall, there was no record of this. Again, the chart appears to have gone missing. 3. The consultant in charge of Mr Ali's care stipulated that his junior medical colleagues should perform neurological observations before Mr Ali could be discharged, yet this did not take place. The sister in charge told me that she asked the registrar if Mr Ali was neurologically stable enough to be discharged, and she said yes. 4. The consultant in charge of Mr Ali's care also stipulated that Mr Ali should undergo physiotherapy assessment before he could be discharged, yet this did not take place. The sister in charge told me that she knew about this and she knew that a physiotherapist was going to review Mr Ali that afternoon. However, she did not pass this information on to the nurse who looked after Mr Ali during the sister's lunch break, nor to Mr Ali's family.

	The nurse said that she did tell Mr Ali's family he was not ready for discharge, but she gave them the discharge paperwork before she went for lunch and so they assumed he could go. Both the doctor and the nurse who gave evidence told me that they now think that discharge packs should not be given out until the patient's discharge is complete. 5. Both the doctor and the nurse thought that it would be helpful to have a nurse accompany the doctors on their ward rounds.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and 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 27 October 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] children of Irshad Ali • [redacted] Royal London Hospital • [redacted] Royal London Hospital 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** 29.08.14	**SIGNED BY SENIOR CORONER**