ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr Alison Diamond** **Chief Executive** **North Devon Healthcare NHS Trust** **North Devon District Hospital** **Raleigh Park** **Barnstaple** **Devon** **EX31 4JB** **2. [redacted]** **South Molton Health Care Centre** **East Street** **South Molton** **EX36 3BZ** **3. [redacted]** **Interim Matron** **South Molton Community Hospital** **Widgery Drive** **South Molton** **Devon** **EX36 4DP**
1	**CORONER** I am Dr Elizabeth Ann Earland, senior coroner, for the coroner area of Exeter and Greater Devon.
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 10 April 2014 I commenced an investigation into the death of Robert Alan JONES aged 84 years. The investigation concluded at the end of the inquest held on 13th day of January 2015. The conclusion of the inquest was Accidental Death including medical Cause of Death being Ia. Acute on chronic subdural haematoma. Ib. Multiple falls due to Cerebral vascular accidents causing left-sided weakness, partial right-sided blindness following central retinal artery occlusion and postural hypertension.

4	**CIRCUMSTANCES OF THE DEATH** The Deceased was admitted to the Acute Stroke Unit at North Devon District Hospital on 7th February 2014 and he had two falls whilst there, the first on 8th February and the second on 9th February. He was transferred to South Molton Community Hospital on 17 February where he suffered four further falls on 19 February, 21 February, 8th March and 20 March 2014. On arrival to South Molton he showed signs of left-sided weakness from a stroke but a CT scan was requested and performed on 27 March at North Devon District Hospital following deterioration, which continued after transfer back to South Molton Community Hospital where he died on 1st April 2014. Prior to the deterioration on 24 March 2014 the contribution of head injury in the deterioration was not recognised and thought to be due to CVD and stroke.
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 no evidence of communication to ensure that all staff including the different GPs visiting, were aware of the total number of falls the patient has sustained. An out of date post falls checklist was used which does not include specific details of the frequency in duration of neurological observations as recommended by NICE, where head injury has occurred and can or cannot be ruled out and the patient did not always have his neurological observations recorded as per the minimum recommended. They were not always recorded correctly on the observation charts.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. (1) Revise the Trust's falls policy to include the recommended frequency and duration of neurological observations based on NICE guidance for patients where head injury has occurred or cannot be ruled out and inclusion of relevant history of falls in handovers of care. (2) Implement a system to ensure the Multi Disciplinary Team (MDT) is aware of the total number of falls. (3) Ensure delivery of targeted training on performing neurological observations for nursing staff at South Molton Community Hospital and as a general communication across the Trust.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 18 March 2015. 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 [redacted] (Daughter 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	**Signed** [redacted] **Dr Elizabeth Ann Earland** **H.M. Senior Coroner for Exeter and Greater Devon** **Dated this 21st day of January 2015**