Regulation 28: Prevention of Future Deaths report

Rufjan BIBI (died 19.09.14)

	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 23 September 2015, I commenced an investigation into the death of Rufjan Bibi, aged 72 years. The investigation concluded at the end of the inquest yesterday. I made a determination that death was the consequence of an accident, when Rufjan Bibi fell in Mile End Hospital at around 1.45-1.55pm on 1 July 2014 and hit her head, at the time suffering from Parkinson's disease. Her medical cause of death was: 1a bilateral bronchopneumonia 1b acute on chronic subdural haematoma 2 Parkinson's disease

4	**CIRCUMSTANCES OF THE DEATH** Ms Bibi was admitted to the Royal London Hospital on 6 June 2014 and then transferred to Mile End Hospital on 12 June for rehabilitation. At the time of admission she was already compromised, as a result of her Parkinson's and also a fall that she had sustained at the beginning of the year causing subdural haematoma. On 1 July, she was seen sitting beside her bed, and was then found on the floor having sustained a head injury. I recognise that it is impossible to prevent falls in hospital completely, just as it is impossible to prevent falls in the community. However, there other matters that I should like to bring to your attention.
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. Ms Bibi's family told me at inquest that when they came to visit Ms Bibi, which they did daily, they often found her in need of changing (she was incontinent), and then had difficulty obtaining prompt nurse assistance. They even found her with faeces in her hair. Whilst this did not impact upon the outcome, it made me question the evidence I had been given about frequent nursing contact, in a way that I would not otherwise have done. (And of course, however busy staff are, it is not a situation that any of us would want for our loved ones.) 2. Family members were also unhappy that a nurse had told them that, if they wanted closer care for Ms Bibi, then they could engage a nurse privately to come to the hospital to look after her. If this is seriously being suggested as the way for a patient in an NHS hospital to receive appropriate care, then it is worrying indeed for all patients. If it is not seriously being suggested, then it seems unkind and unnecessary.

	3. Having been found at just before 2pm, Ms Bibi did not receive a consultant review until 7pm, and arrangements were then made for her transfer to the Royal London Hospital. During the intervening five hours, she had a Glasgow Coma Score of ten, yet no witness was able to explain the delay.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 13 April 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Care Quality Commission for England • Professor Dame Sally Davies, Chief Medical Officer for England • [redacted], granddaughter of Rufjan Bibi 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** 11.02.15