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. Chief Executive, Sherwood Hospitals NHS Foundation Trust**
1	**CORONER** I am Mrs Heidi Connor, assistant coroner for the coroner area of Nottinghamshire.
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 17 November 2014 I commenced an investigation into the death of Mrs Elizabeth Ann Cox, aged 84. The investigation concluded at the end of the inquest on 11 March 2015. The conclusion of the inquest was Accident. The cause of death was : 1a subdural haemorrhage 1b Fall 2 Rheumatoid arthritis, myeloproliferative disorder, previous subdural haemorrhages, epilepsy, dementia, postural hypotension.
4	**CIRCUMSTANCES OF THE DEATH** As is evident from the cause of death, Mrs Cox had a number of co-morbidities. She had suffered earlier falls, including previous falls whilst an in-patient of the trust on 14 June 2014 and 9 July 2014. Mrs Cox's final admission to Kingsmill Hospital was on 8 July 2014, after suffering a fit. She was admitted to ward 42 on 11 July 2014. The evidence showed that she was risk-assessed for falls, and it was clear that she was at high risk. Mrs Cox had a history of stroke, previous falls and SDHs, fits, postural hypotension, dementia, mobility problems, poor eyesight and was aged 84. It was accepted in evidence that this assessment should have resulted in Mrs Cox being nursed in a Hi-Lo bed and crash mats being provided. This equipment was not put in place. Mrs Cox suffered a fall from her bed in the early hours of 18 July 2014. The fall was unwitnessed, although later investigations revealed that Mrs Cox had been trying to get out of her bed to go to the toilet as she had loose stools. Although she had a buzzer, she was not able to use this. Mrs Cox' condition deteriorated significantly after this fall, and she died at Kingsmill Hospital on 10 August 2014. I found there was a clear link between the fall on 18 July

	2014 and her death.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. The evidence of senior nursing staff involved with this ward and with the trust's internal investigation made it clear that those working on the ward on the night of 17/18 July felt they needed further staff to cope with the demands of the patients they were looking after. We heard that the ward sister followed hospital protocol to request assistance. When it was clear that no one was available from neighbouring wards, a bank nurse was requested. Unfortunately, the bank nurse cancelled at very short notice. The duty nurse manager was called, but noone was available to assist at short notice. 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. During daytime hours, where additional staff are needed, the Reducing Harm Team can be contacted to try to provide the necessary resources. I was told, although this is currently under review, that,as matters stand, this (or an equivalent) is not available during the night. 2. It has been suggested as part of a trust-wide review that the number of staff available on the wards at night be reduced – from 3 registered and 2 unregistered currently, to 3 registered and 1 unregistered. I am aware that this is merely a proposal – and not currently in place – but should this come into effect, I am concerned that events like these may re-occur, where staff simply do not have the capacity to look after their patients safely, because of workloads.
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 7 May 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, the trust's legal department and to Mrs Cox' family. 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	**12th March 2015** [redacted]