REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **West Midlands Ambulance Service NHS Trust** 2. **The Dudley Group NHS Foundation Trust (Russells Hall Hospital)** 3. **Care Quality Commission (CQC).**
1	**CORONER** I am Mr Zafar Siddique, Senior Coroner, for the coroner area of Black Country.
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 9 April 2015, I commenced an investigation into the death of Mr Frederick White. The investigation concluded at the end of the inquest on 28 May 2015. The conclusion of the inquest was a narrative conclusion: Mr White sustained a fall on the 29 March 2015 which caused a traumatic spinal cord injury. There were failures in recognising his symptoms when paramedics arrived at the scene and failures to properly immobilise him using a cervical spine collar. There were also further failures in his care when he arrived at Russells Hall Hospital during further assessment and immobilisation. Overall I am satisfied on the balance of probability that these collective failures more than minimally, trivially or negligibly contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** 1. On Sunday 29 March 2015 around 14:20 hours, [redacted] suffered a fall when getting up from the toilet and hit his head when coming to rest on the bathroom floor at the Lime Gardens Retirement Home. Mrs White activated the alarm and carers were on the scene very quickly. Mr White described he couldn't move his legs and was uncomfortable. He had also sustained a cut to his head. 2. A member of the care staff, [redacted] described his symptoms included pain and also symptoms of numbness. They phoned for an ambulance and decided not to move him in case he had a serious injury. 3. The first responder on the scene was the Paramedic, [redacted] who arrived at 14:55 hours and began his assessment and gained a history of what had happened. There was no loss of consciousness and he checked neck and back and primary survey suggested there was no pain or deformity. He also described that there was aching in numbness in his right shoulder. He followed this with a second survey and described observations were normal and administered paracetamol via a cannula. 4. Additional paramedics arrived and he was moved onto a scoop stretcher and taken to Russells Hall Hospital. A decision had been taken not immobilise him throughout with a neck collar or supports. On route he was further assessed

	and it was noted he had a drop in blood pressure. 5. On arrival at Russells Hall Hospital, he was assessed by a triage nurse on admission at 17:23 and then seen by a junior doctor at 19:40hours (2 hours 41 minutes later). A diagnosis of head injury and possible cervical spine injury was made and he was then immobilised in a collar, blocks and tape. The CT scan showed marked mal-alignment at C3/4 vertebra. He was found sat up at 1:35am with a cervical spine collar up around his mouth and this was repositioned correctly. 6. Over the course of the next few days the extent of his injury became apparent and that he had sustained a serious life limiting cervical cord compression and the prognosis was extremely poor. His condition deteriorated and sadly he died on the 2 April 2015. 7. The medical cause of death was given as: 1a. Traumatic spinal cord injury 1b. Accidental fall II. Ischaemic Heart disease
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) Spinal injuries are relatively uncommon but have the potential to cause significant morbidity and mortality if not managed effectively. Mr White was an elderly patient who was at risk of falling and during the course of the inquest evidence emerged showing that he had sustained a traumatic injury of significant blunt force trauma. He also gave a description of feelings of numbness and lack of sensation in his legs and there was also a drop in blood pressure, which should have prompted a conservative approach in treating the patient by applying immobilisation on suspicion of spinal cord injury during his initial examination and assessment. (2) Evidence emerging from the inquest suggested that the initial failure to immobilise the patient then continued when he arrived at Hospital and the triage process failed to adequately assess the risk again. It appears the triage process is heavily reliant upon the handover from the paramedic crew without further and detailed assessment. (3) It wasn't until five hours after the initial fall that a suspected spinal cord injury was diagnosed. (4) In light of the inquest findings, you may consider that the guidelines and policy in the assessment and management of actual and potential spinal injuries my need to be examined.
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 29th July 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, Mr Ward's 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	**3 June 2015** [redacted]