REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Medical Director, Barts Health NHS Trust**
1	**CORONER** I am Jacqueline Devonish, assistant coroner, for the coroner area of Inner North London
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 November 2015 I commenced an investigation into the death of David Alan White. The investigation concluded at the end of the inquest on 10 November 2015. The conclusion of the inquest was accident contributed to by neglect with a medical cause of death as follows: 1a Bronchopneumonia and acute on chronic transplant kidney failure 1b Valvular, ischaemic and hypertensive heart disease, right foot ischaemia and fractured neck of right femur.
4	**CIRCUMSTANCES OF THE DEATH** Mr White was admitted to the Royal London Hospital on 11 June 2015, where he remained until his death on 26th June. The original admission followed a presentation to the GP with significant pain from his arterial vascular disease on 4 June. On admission to hospital his Warfarin was changed to Heparin, and the family informed the nurses that this had led to confusion and hallucinations for Mr White. On 12 June 2015 the hospital records demonstrate that Mr White had been risk assessed for mobility, and that the following actions had been agreed: 1. Call bell to be within reach 2. Supervised transfers 3. Physiotherapy and Occupational Therapy At 21:40 hours on 18 June 2015 Mr White sustained an unwitnessed fall on the ward. He said that he fell backwards onto his bed when reaching for a urine bottle. He was not injured. His care plan was reviewed and the bedsides rails decision was reviewed. At 08:45 hours on 19 June 2015 Mr White sustained another unwitnessed fall. He was found lying on the floor. He explained that he had slipped when attempting to get something out of the bedside locker. X-rays revealed a right hip and right shoulder fracture, but did not identify fractured ribs, predominantly on his right side.

	On 21 June 2015 he underwent emergency surgery for the fractured right neck of femur. Following surgery he was admitted to the intensive care unit where he remained intubated and ventilated, in addition to being on a Hemofilter. On 24 June 2015 he was stepped down to the Renal High Dependency unit, but remained unwell with a likely infected dialysis catheter. He died on 26 June 2015 at 21:55 hours.
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) The effect of Heparin, in causing confusion, was not in the records, and therefore not acted upon. (2) Nursing notes documented a risk of falls/mobilisation and action to be taken, but there was no supervision arrangement in place. One to one care had been in contemplation. (3) Whilst nursing notes were being kept about the risks, the records were not being reviewed and acted upon.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 15 January 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 Person, [redacted] 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	**11 November 2015**