REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

<table>
<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Mr Miles Scott,
Chief Executive,
St George's Hospital,
Blackshaw Road,
Tooting,
London.
SW17 0QT.</td></tr>
<tr><td>1</td><td>CORONER

I am Dr Fiona Wilcox, Senior Coroner, for the coroner area of Inner West London</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION

On the 30th day of July 2015 I opened an investigation touching the death of Leslie Douglas Murray, who died aged 89 years on the 28th July 2015 in St George's Hospital

The inquest was concluded on the 13th January 2016 at Westminster Coroner's Court.

The medical cause of death was recorded as:

1(a) Bronchopneumonia.
(b) Acute Subdural Haemorrhage and Cervical Spine Fracture.
(c) Fall

2 Chronic Obstructive Pulmonary Disease and Hypertension.

How, when and where and in what circumstances the deceased came by his death:

On the 24/7/2015, Mr Murray fell down stairs sustaining injuries including spinal injuries at home. He was admitted to Frimley Park and then St Georges Hospital. He was assessed as requiring 1:1 nursing care, but cover was not available. On 27/7/2015 he fell from his bed sustaining further injuries that led to and caused his death. If the extra cover had been in place to provide him with 1:1 care, this fall would have been prevented. He died on 28th July 2015

Conclusion of the Coroner as to the death:

Accident</td></tr>
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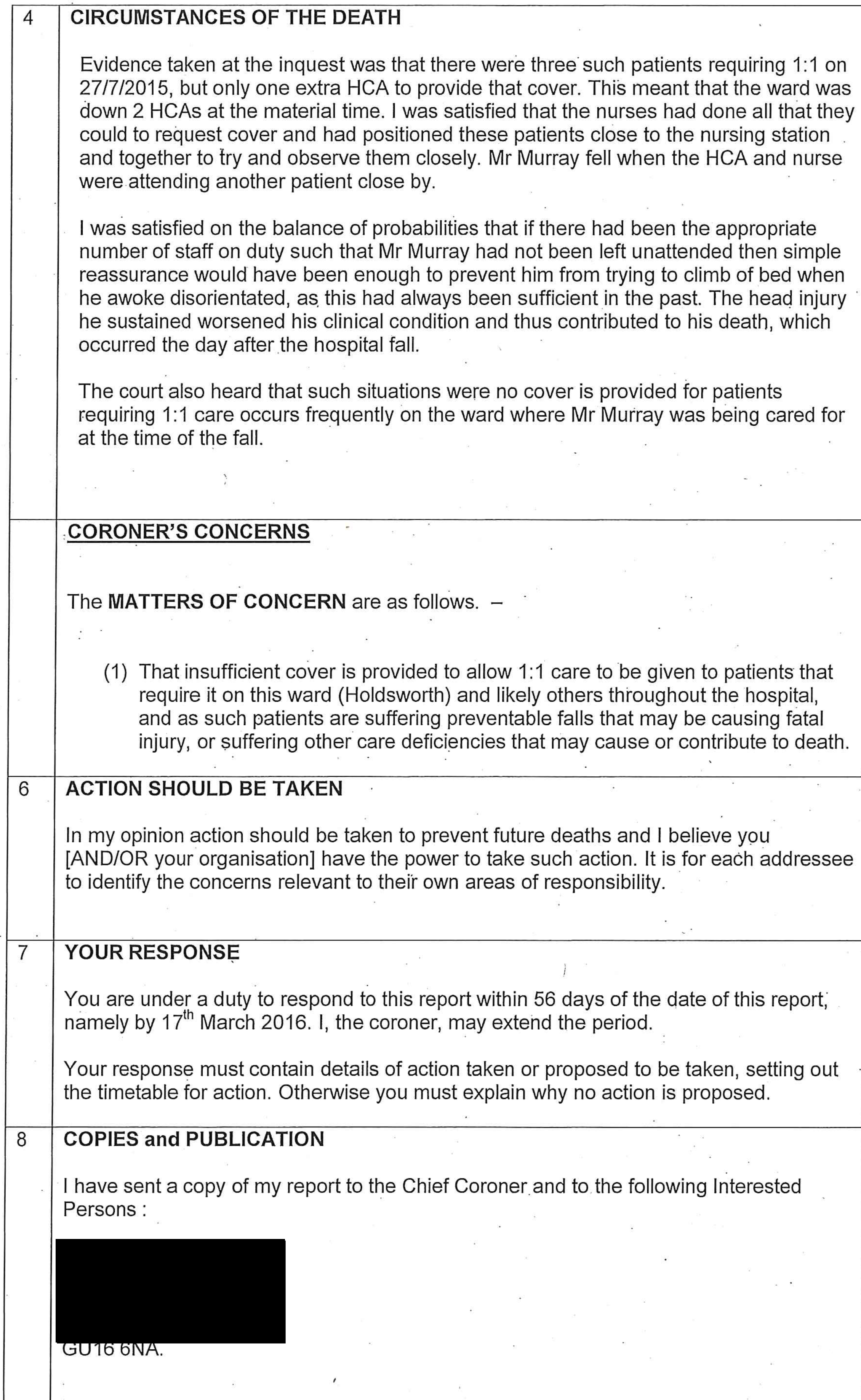


4 CIRCUMSTANCES OF THE DEATH

Evidence taken at the inquest was that there were three such patients requiring 1:1 on 27/7/2015, but only one extra HCA to provide that cover. This meant that the ward was down 2 HCAs at the material time. I was satisfied that the nurses had done all that they could to request cover and had positioned these patients close to the nursing station and together to try and observe them closely. Mr Murray fell when the HCA and nurse were attending another patient close by.

I was satisfied on the balance of probabilities that if there had been the appropriate number of staff on duty such that Mr Murray had not been left unattended then simple reassurance would have been enough to prevent him from trying to climb of bed when he awoke disorientated, as this had always been sufficient in the past. The head injury he sustained worsened his clinical condition and thus contributed to his death, which occurred the day after the hospital fall.

The court also heard that such situations were no cover is provided for patients requiring 1:1 care occurs frequently on the ward where Mr Murray was being cared for at the time of the fall.

CORONER'S CONCERNS

The **MATTERS OF CONCERN** are as follows. –

(1) That insufficient cover is provided to allow 1:1 care to be given to patients that require it on this ward (Holdsworth) and likely others throughout the hospital, and as such patients are suffering preventable falls that may be causing fatal injury, or suffering other care deficiencies that may cause or contribute to death.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to identify the concerns relevant to their own areas of responsibility.

7 YOUR RESPONSE

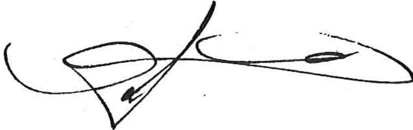
You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th March 2016. I, the coroner, may extend the period.

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 :

GU16 6NA.

	David Behan Chief Executive CQC Citygate Gallowgate Newcastle upon Tyne NE1 4PA Simon Stevens Chief Executive NHS England PO Box 16738 Redditch B97 9PT Ms [redacted] Ward Manager Holdsworth Ward St George's Hospital Blackshaw Road London SW17 0QT. 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	**21st January 2016.**  **Dr Fiona Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65 Horseferry Road** **London** **SW1P 2ED.**