REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ms Kath Kelly, Chief Executive, George Eliot Hospital NHS Trust** **2. Dr Mike Durkin, National Director of Patient Safety, NHS England** **3. Dr Ruth Hussey OBE, Chief Medical Officer, Welsh Government**
1	**CORONER** I am David Clark, Assistant Coroner for the coroner area of Warwickshire.
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 31 December 2015, I commenced an investigation into the death of Eileen Annie Thompson, aged 92 years. The investigation concluded at the end of the inquest on 12 February 2016. The conclusion of the inquest was that Mrs Thompson died from head injuries, namely a fractured base of skull and intracrainial bleeding. I recorded a conclusion of accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Thompson, who had been diagnosed with dementia, lived with her son and daughter-in-law. She sustained a right-sided fractured neck of femur and was admitted to George Eliot Hospital, Nuneaton, on 1 November 2015. Prior to her discharge from hospital, a site visit was carried out at her address by an Occupational Therapist to assess whether equipment would be needed to assist with Mrs Thompson's on-going mobility and rehabilitation needs. As a result of this visit, a hoist and a Minuet bed were ordered. Following the delivery and installation of the equipment, Mrs Thompson was discharged from hospital on 20 November 2015. Due to the size and shape of her room, the bed was positioned along a wall. The bed had four wheels, one on each corner, with a separate locking mechanism for each wheel. The position of the bed against the wall meant that only the two outer wheels could be locked. The two inner wheels (that is, those on the side against the wall) could not be reached once the bed was in position, and so those two wheels were not locked. During the evening of 29 December 2015, Mrs Thompson's daughter-in-law discovered that Mrs Thompson had fallen between the bed and the wall. The bed had moved from the wall. Mrs Thompson had sustained serious head injuries. She was taken by ambulance to George Eliot Hospital, where she died shortly after admission.

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 could 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 bed was able to move from the wall because the two inner wheels were not locked. (2) The locking mechanism for the inner wheels was not easily accessible when the bed was placed against a wall. (3) There is risk of recurrence in respect of service users who are provided with this type of bed when the bed is placed against a wall.
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. The action should include an explanation of the steps you have taken to raise awareness of the risk and to issue appropriate instructions regarding the locking of wheels.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 April 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 Mrs Thompson's son and daughter-in-law. I have also sent it to the Managing Director of the company which supplied the bed on behalf of the George Eliot NHS Trust. I am 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	**DATE of REPORT** **15 February 2016** **David Clark, Assistant Coroner**