REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Sandwell and West Birmingham Hospitals NHS Trust** **2. Family of the late Mrs Farmer.** **3. Care Quality Commission-** [redacted]
	CORONER: I am Zafar Siddique, Senior Coroner, for the coroner area of the 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 the 7 September 2016, I commenced an investigation into the death of the late Mrs Beryl Farmer. The investigation concluded at the end of the inquest on 23 November 2016. The conclusion of the inquest was a short narrative conclusion of: Accidental death contributed to by neglect. The cause of death was: 1a Subdural Haemorrhage II Ischaemic Heart Disease, Hypertension, Left Ventricular Failure, Atrial Fibrillation, Type 2 Diabetes Mellitus, Chronic Kidney Disease
4	**CIRCUMSTANCES OF THE DEATH** 1. Mrs Farmer was a 77 year old woman with a medical history including chronic kidney disease, ischaemic heart disease, hypertension, diabetes, dextrocardia and situs inversus. She was admitted to Sandwell Hospital on the 20 June 2016 after experiencing symptoms of loss of appetite, weight loss and nausea. 2. She was diagnosed with severe hypocalcaemia secondary to severe vitamin D deficiency. She also had significant postural hypotension with a drop of 25mmHg on standing. She received intravenous calcium infusions for treatment. 3. On the 23 June shortly after 6am she had a fall from her bed and sustained an injury to her face and head. This resulted in bruising to her right eye area and her forehead. No CT scan was performed at this stage because it was concluded that her GCS was 15/15 and no evidence of vomiting, and her key observations were normal. 4. She was later discharged on the 24 June 2016. No documentation for a falls risk assessment was available or had been completed. 5. In addition a decision had been taken to move her from a monitored area to a de-monitored area prior to the fall without consultation with the medial team.

	6. There was also a failure to perform further neurosurgical observations after the first set of observations before discharge. 7. At home, her condition declined and she developed headaches and was readmitted back to Sandwell Hospital on the 1 July 2016. A CT scan was performed on this occasion and a subdural haemorrhage diagnosed. 8. Advice from neurosurgeons was sought and she was managed conservatively. She then effectively remained in Hospital and went on to develop seizures as a result of the subdural haemorrhage and sadly died on the 30 August 2016.
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. Evidence emerged during the inquest that Mrs Farmer had a risk of a falling (moderate to high risk). There was no evidence that a falls risk assessment had been completed. 2. Given the risks of falls, there was no clear justification for moving her from a monitored bay to an unmonitored bay. 3. After the fall, only one set of neurological observations were performed before her discharge. 4. In addition no CT Head scan was performed despite evidence of significant bruising to her face and head.
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. 1. You may wish to consider further training for all those involved in this incident in respect of requirements for managing risks of falls. 2. In addition you may consider it is prudent in light of this incident to review your policy on performing CT head scans particularly for those patients where there is evidence of bruising to the head area.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 January 2017. 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; Family and Care Quality Commission. 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	**24 November 2016** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**