DAVID W. G. RIDLEY
Senior Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms Nerissa Vaughan Chief Executive Great Western Hospitals NHS Foundation Trust Marlborough Road Swindon SN3 6BB
1	**CORONER** I am DAVID W. G. RIDLEY, Senior Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 02 May 2017 I commenced an investigation into the death of Francis Mortimer LANGLEY and opened his Inquest on 12 May 2017. Francis was born on 21 October 1938 in Swindon and sadly died at the Great Western Hospital on 30 April 2017. He was 78 years old. I concluded Francis' Inquest on Friday 01 September 2017 having had documentary evidence in front of me including his hospital records. I recorded that his cause of death was as follows:- 1a) Hospital acquired pneumonia 1b) Immobility 1c) Thoracic spinal fracture due to fall (November 2016) II. Ankylosing spondylitis and chronic pulmonary disease
4	**CIRCUMSTANCES OF THE DEATH** Briefly, the evidence pointed to Francis falling from a step ladder in the garden of his home in Swindon early November. He went to the doctor with increasing discomfort in his legs and ultimately was admitted to the Great Western Hospital on 09 November 2017. He was according to [redacted] found to have multiple fractures from T5 –T10 and was taken to theatre on 11 November where he underwent the "posterior instrumented fusion for multiple spinal fractures from T5 – T10 using Expedium De-Puy". The procedure was carried out by [redacted] He was found during the process to have suffered a thoracic cord injury. Post post operatively he lost the power (a recognised complication of such an injury) in his right leg as well as his left leg and as such ultimately was paralysed from the waist down. Due to his immobility he was treated for urosepsis in December but on 30 January 2017 was transferred to Forest Ward which I understand is part of the Swindon Intermediate Care team for inpatient rehabilitation. On 17 February he fell out of bed onto the floor and although was found to have sustained a C7 fracture but given his state of immobility already I did not find this fall contributed to Francis' death. He underwent a second surgical procedure but as stated he was already immobile and therefore already a candidate for further infections which sadly materialised including the hospital acquired pneumonia from which he died on 30 April 2017.

5	**CORONER'S CONCERNS** As part of the evidence when there is a fall in hospital (and I understand that SWICC is now part of Great Western Hospital hence I am writing to you). I always look at the risk assessments. For ease of reference I have enclosed with this letter marked A, a copy of the earliest assessment that I can on file dated 14 December 2016 in Great Western Hospital format which as you will see in response to the question as to whether or not the patient was admitted due to the fall or has fallen since admission and is at the risk of falling again the response is "Yes", although the ultimate decision was not to engage bed safety rails. As already stated Francis was transferred to SWICC on 30 January 2017 and I have been supplied with a screen dump image marked B showing the two assessments carried out on 30 January and 12 February 2017. The style is very different to the Great Western Hospital approach and in conjunction with this I have regard to a statement from [redacted] who was the Forest Ward Manager at the relevant time marked C. You will see at the bottom of his statement that the reason safety bedrails were not engaged is the fact that Francis did not have a history of falls from bed. I have to say that I am somewhat concerned and found the questions raised by the SWICC assessment and responses to be contradictory. By way of example I will refer you to the assessment that was carried out on 12 February a few days before the fall from bed on 17 February 2017. In response to the question as to whether or not Francis was at risk from falls from bed the answer was "Yes and No". In relation to whether or not the patient could injure themselves against the rails due to spasms or uncontrolled movements, the answer was "Yes" yet in response to Does the patient have any behaviour that may interfere with the correct use of the safety rails the answer was "No". The latter two responses to me contradict each other. Francis was noted that he would have been compliant with the use of safety rails. I have dealt with many cases whereby patients have fallen from their bed or chairs or simply collapsed whilst on the ward resulting in that patient sustaining a head injury from which they have died. To me given Francis' immobility and the fact that he was in a condition with lower limb paralysis that was essentially alien to him and which involved involuntary movements I am concerned that when assessing the risk as to why safety rails were not engaged in the absence of any mental disorder. I know this is a concern shared by his widow. To me the risk of knocking a lower limb against one of the rails is outweighed by protecting a patient against the risk from falling from a bed and sustaining in particular a serious head injury. In reading the SWICC approach it is almost as if the fact that Francis had not had a fall from bed already predetermines that he is not at risk which to me seems an odd way of risk assessment. I would be grateful if you could please look at the inconsistency that appears to exist between the approach to the use of bedrails on the Forest Ward as compared to the rest of Great Western Hospital as I have said the SWICC assessment concerns me in that it is overly complicated and as I have demonstrated has given rise to conflicting answers as part of the assessment process. I would also be grateful for the Trust's consideration in relation to the policy deployed generally when patients suffer whole or partial paralysis as to whether or not automatically those patients should be subject to bedrails. I appreciate it is not entirely black and white but I do find it surprising and I am concerned that bedrails were not engaged as at the 17 February 2017 although as already stated and I wish to emphasise I did not find that the fall contributed to his death.
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 30 October 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

	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	Dated 04 September 2017 Signature Senior Coroner for Wiltshire and Swindon

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