	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: East Kent Hospitals University NHS Foundation Trust**
1	**CORONER** I am Kate Thomas Assistant Coroner for **Central and South East Kent**
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 12/06/2017 I commenced an investigation into the death of Harold Graham WONFOR. The investigation concluded at the end of the inquest 14th September 2017. The conclusion of the inquest was Harold Wonfor was admitted to the William Harvey Hospital on the 22nd of January 2017 with a history of falls which was not recognised. On the 24th of January he had an unwitnessed fall on Cambridge L ward sustaining a Subdural Haematoma from which he declined and subsequently died on the 30th January 2017. 1a **Acute Subdural Haematoma** b c II **Asbestosis**
4	**CIRCUMSTANCES OF THE DEATH** Following his admission to the Kent and Canterbury Hospital on the 21st of December 2016, Harold Wonfor sustained a number of falls whilst on the ward. Clinical investigation concluded that there had been no subsequent injury although it was well documented that he was frail, HAD a number of co-morbities and presented a falls risk. He was discharged on the 5th January 2017 into the care of his family. On the 22nd of January he was admitted in the William Harvey Hospital where be presented as being confused with reduced mobility. He was transferred to the CDU (Clinical Decisions Unit) for assessment. Hospital policy dictated that a falls assessment should be done within 6 hours of admission but such time should be abridged where the patient is vulnerable or a clear falls risk. Mr Wonfor was not assessed during the 24 hours he remained in the CDU in contravention of Hospital Policy. On the 24th of January he was transferred to Cambridge L Ward. At the time of transfer no falls assessment had been done and there were no falls prevention measures in place. At the very least Mr Wonfor should have been met by a Nurse upon arriving on the Ward and placed in an observation bed. This did not happen. Approximately 30 minutes after arriving on Cambridge L Ward, Mr Wonfor had an un-witnessed fall during which he struck his head on a sink and sustained a Subdural Haemotoma from which he subsequently declined and died on the 30th of January 2017.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Between January 2017 and April 2017 five deaths occurred on Cambridge Wards at William Harvey Hospital. Common to each was the fact that the death was caused as a result of a fall on the ward in circumstances where falls risk assessments were either inadequate, incomplete, not reviewed or not enforced. Inquests in respect of each the deaths have been held, the last in November 2017. The Trust was given an opportunity following the earlier inquests to provide evidence of changes to practice following the deaths. It is recognised that at the time of hearing the inquests much work has already been done to address these issues but that work is ongoing and parts of that work have not yet been implemented/were in the process of being implemented. It is for this reason that Regulation 28 reports arise from three of the deaths. (2) That the policies and procedures for falls risk assessment is inadequate especially for the vulnerable (3) There is inadequate monitoring and enforcement of the falls prevention policies and procedures in place

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you East Kent Hospitals University NHS Foundation Trust 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 **16th January 2018**. 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: Next of Kin. I have also sent it to Care Quality Commission who may find it useful or of interest. 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	20/11/2017 Signature:  Kate Thomas Assistant Coroner **Central and South East Kent**