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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: East Kent Hospitals University NHS Foundation Trust** |
| 1 | **CORONER**<br><br>I am Patricia Harding Senior Coroner for **Central and South East Kent** |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 09/03/2017 I commenced an investigation into the death of Henry George HONOUR. The investigation concluded at the end of the inquest 18th September 2017. The conclusion of the inquest was Henry Honour died on 21st February 2017 at William Harvey Hospital from a bronchopneumonia occasioned as a result of immobility and insult from a non-displaced transcervical fracture to the left neck of femur sustained as a result of a fall on Cambridge L ward on 4th February 2017<br>1a **Bronchopneumonia**<br>b **Fractured Neck of Femur (operated)**<br>c **Fall**<br>II **Biological Frailty** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>Mr Honour presented to the Accident and Emergency department at William Harvey Hospital on 1st February 2017 after two falls. He was very frail with general debilitation and had recently suffered a pneumonia and acute kidney injury for which he was still on antibiotics. After a period on the clinical decision unit he was admitted to Cambridge L ward on 2nd February 2017 for further investigations.<br>On 3rd February 2017 Mr. Honour was seen by a consultant on a ward round who found him to be very frail and cachetic with tachycardia. His pneumonia and acute kidney injury were resolving. The consultant ordered a CT chest, abdomen and pelvis to investigate his weight loss and reduced functionality and a blood test but was of the opinion that Mr. Honour was not particularly medically unwell and if his blood tests were normal he could be discharged from hospital.<br>At approximately 22.45 on 4th February 2017 Mr. Honour suffered an unwitnessed fall on the ward in circumstances where he had needed to use the toilet and had either tried to climb over or around the rails on his bed which were raised. He was found by a nurse lying on the floor by his bed. Mr Honour reported no pain, he had no apparent injury and could move all his limbs. He was transferred back to his bed and his observations were taken all of which were within normal limits. Mr Honour was assessed by a doctor at 01.50 on 5th February 2017 who found no obvious injury.<br>That Mr. Honour had suffered an undisplaced transcervical fracture to his left hip was not discovered until 8th February 2017. He underwent a cemented hemiarthoroplasty the following day but did not make a good recovery following the procedure and sadly died on 21st February 2017 after contracting a bronchopneumonia on 10th February 2017 which did not respond to treatment. |
| 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) 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) In respect of Mr Honour the falls risk assessment completed on admission was at best perfunctory, as were subsequent reviews which did not rectify earlier errors or recognise the need for precautionary measures to be taken when Mr. Honour should have been nursed in an observable bed with a falls alert and hip protectors in light of the risks posed.

(3) The bedrail risk assessment was difficult to interpret in light of the falls risk assessment, bed rails were utilised when they should not have been.

(4) The falls risk assessment was not updated post fall and no protective measures were put in place.

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>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.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Next of KinI have also sent it to Care Quality Comission who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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<br><br>Signature:  <br><br>Patricia Harding Senior Coroner **Central and South East Kent** |