Regulation 28: Prevention of Future Deaths report

William Henry BERGMAN (died 20.12.16)

	THIS REPORT IS BEING SENT TO: **1. Dr Alistair Chesser** **Chief Medical Officer** **Barts Health** **Royal London Hospital** **Whitechapel Road** **London E1 1BB**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 29 December 2016, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of William Bergman, aged 88 years. The investigation concluded at the end of the inquest earlier today. The jury made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Mr Bergman, who suffered with vascular dementia, was admitted to the Royal London Hospital and diagnosed with pneumonia. He died following an impact to his forehead sustained while healthcare assistants were changing him on 19 December 2016, variously described as hitting it on the cot side or on the side of the nearby television.

	His deterioration was noted several hours after the incident, and when he was then scanned, he was found to have sustained a subdural haematoma and a massive intracranial bleed.
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. The staff nurse who was called to see Mr Bergman after the accident, quickly formed the opinion that he was fine. Although the medical records were not available for consideration because Barts Health has been unable to locate them, she said that she would not go into detail such as whether he felt sick. She did not ask for immediate general observations, then to be repeated. She did not ask for immediate neurological observations, then to be repeated. She did not ask for a medical review. She said very candidly that she did not consider the possibility of a minor head injury in an elderly person with vascular dementia and liver cirrhosis having the potential for a major consequence. When she noted a bruise (which a family member attending Mr Bergman that day described as being accompanied by a lump) some hours later, she did not change her management plan. She completed a Datix report only the following day, after Mr Bergman's death. The staff nurse said in court how sorry she was that she had not acted differently, and described her contact with Mr Bergman as career changing. The reason I write to you now is because if one staff nurse responded in this way to a head injury, immediately assuming that it was minor and therefore with minor consequences, then others may behave in the same way.
6	**ACTION SHOULD BE TAKEN**

	In my opinion, action should be taken to prevent future deaths and I believe that 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 2 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted], daughter of William Bergman 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 31.10.17