REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Dr P. Miller, Chief Executive, Leicestershire Partnership NHS Trust.**
1	**CORONER** I am Lydia Brown, Assistant Coroner for Leicester (City and South)
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 12/09/2016 I commenced an investigation into the death of Margery Annie Astill, 79. The investigation concluded at the end of the inquest on 09 June 2017. The conclusion of the inquest was Accidental death & attached sheet. Question 1a. Did Mrs Astill have a care plan during her admission, if not, should one have been put in place? Answer. No care plan but there should have been one as only had a community care plan. 1b. Was there an effective "named nurse" system, and if not, should there have been? Answer. Insufficient evidence. 2. Was Mrs Astill assaulted by a patient on 29 August 2016, sustaining a head injury that required hospital treatment? Answer. Yes as seen on CCTV. 3. Should the safeguarding team and family of Mrs Astill have been informed on 30 August 2016 that she had been the victim of an assault? Answer. Yes. 4. Was the ward adequately staffed on 2 September 2016? Answer. No, ward had 5 staff instead of 6. 5. Were designated patient observation levels properly maintained on the afternoon of 2 September 2016? Answer. No as not all observations were completed. 6. Could any additional steps have been taken by the ward nursing staff or medical team to address the agitated patient's escalating behaviour of running around the ward on 2 September 2016? If so please set these out from the evidence available to you. Answer. Nothing more could have been done. Cause of death: 1a Bronchopneumonia 1b Traumatic axonal injury
4	**CIRCUMSTANCES OF THE DEATH** On the 27th August 2016 the deceased had been admitted to the Evington Centre having been detained under Section 2 of the Mental Health Act. On the 2nd September 2016 the deceased collided with another agitated patient who was running around the ward, causing her to fall to the ground in the Wakerley Ward corridor. She was taken to the Leicester Royal Infirmary on the same day, and diagnosed with unsurvivable head injuries. She died 3 days later on the 5th September 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) Diary systems for ensuring referrals to different specialisms were not effective, such as for physiotherapy and the failure of these systems was not identified until the inquest was held. Furthermore, the system for entering and updating/amending incident reporting was unclear and reported incidents were not reviewed by a senior employee in a timely fashion on this occasion. (2) Communication with family members was inadequate and inaccurate, the "named nurse" system was ineffective and therefore opportunities were lost to share information and to keep the family informed and involved. The failure of the Trust to engage with family members of patients with mental health issues have been raised in the past as a concern, and contrary to NICE Guidelines. (3) Mrs Astill had two unwitnessed falls during her time in the unit, both were recorded on CCTV and both were due to interaction with other patients. The first fall was quickly attended by numerous nursing staff members, but there was a considerable delay in actually physically attending to the patient, examining her or taking basic observations. In a professional nursing environment this delay in first aid provision was of concern and the Trust should consider enhanced training to ensure immediate effective interventions
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 Tuesday 5th September 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: [redacted] (son), [redacted] (daughter). Mr J. Adler, Chief Executive, University Hospitals of Leicester NHS Trust. Sir David Behan, Chief Executive, Care and 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 their lease or the publication of your response by the Chief Coroner.
9	**[DATE]** **11th July 2017** **[SIGNED BY CORONER]**