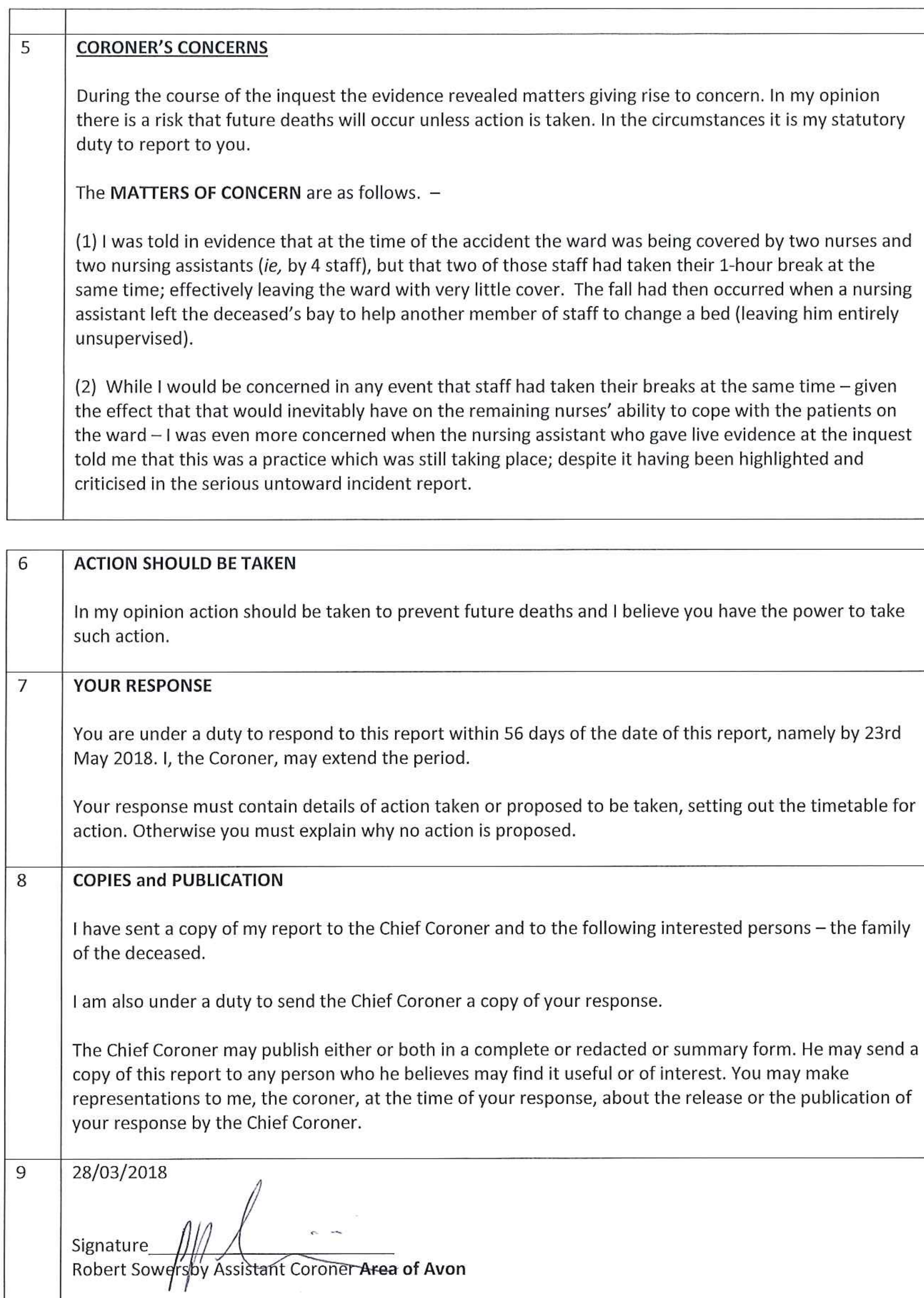
M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

28th March 2018 REF: 6615

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **University Hospitals Bristol NHS Trust** **Trust Headquarters** **Marlborough Street** **Bristol** **BS1 3NU**
1	**CORONER** I am Robert Sowersby Assistant Coroner for **Area of Avon**
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 30th May 2017 an investigation into the death of John Frederick Wherlock, aged 90 years, was commenced. The investigation concluded at the end of the inquest on 23rd February 2018. The conclusion of the inquest was as follows: The medical cause of death was recorded as 1a) Gastrointestinal bleed 2) Hip fractures (operated), frailty, chronic kidney disease The narrative conclusion was recorded as: **Mr Wherlock already had a fractured hip and was at a high risk of further falls. He was left unsupervised and fell again, suffering a second fracture. Sadly his condition deteriorated and he died in Bristol Royal Infirmary on 23 May 2017.**
4	**CIRCUMSTANCES OF THE DEATH** The deceased was an inpatient on Ward 518 at the BRI. He was elderly and confused, had already suffered a fractured hip in one fall, and was at a high risk of further falls. He was left unsupervised and during that time tried to get out of bed: he fell again, fracturing his hip on the other side, and that fracture contributed to his subsequent death.



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) I was told in evidence that at the time of the accident the ward was being covered by two nurses and two nursing assistants (*ie,* by 4 staff), but that two of those staff had taken their 1-hour break at the same time; effectively leaving the ward with very little cover. The fall had then occurred when a nursing assistant left the deceased's bay to help another member of staff to change a bed (leaving him entirely unsupervised). (2) While I would be concerned in any event that staff had taken their breaks at the same time – given the effect that that would inevitably have on the remaining nurses' ability to cope with the patients on the ward – I was even more concerned when the nursing assistant who gave live evidence at the inquest told me that this was a practice which was still taking place; despite it having been highlighted and criticised in the serious untoward incident report.

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 23rd May 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 – the family of the deceased. 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	28/03/2018 Signature______________________ Robert Sowersby Assistant Coroner ~~Area~~ **of Avon**

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