H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive, Ms D Lee, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Royal Hospital, Great Western Road, Gloucester, GL1 3NN**
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 the 17th April 2018 I commenced an investigation into the death of Graham Philip Jones. The investigation concluded at the end of the inquest on the 5th April 2019. The conclusion of the inquest was a hybrid conclusion of accidental death and a narrative conclusion. The medical cause of death was 1A subdural haematoma, 2 repaired perforated duodenal ulcer.
4	**CIRCUMSTANCES OF THE DEATH** Mr Jones was a 63 year old man with a significant medical history that included end stage renal failure, he had been receiving dialysis since January 2016, hypertension, stroke and prostatic cancer. On the 5th March 2018 he was admitted to hospital suffering with vomiting and abdominal pain. Later that day he underwent a laparotomy and repair of a perforated duodenal ulcer. Post operatively he was transferred to the high dependency unit within the department of critical care for monitoring. Whilst there he experienced two unwitnessed falls on the 14th and 15th March 2018. The staff caring for him were aware that he was at risk of falling. They had put in place steps to reduce that risk, and after the first fall they instigated further preventative measures. A thorough handover of his care provision was done when he was transferred to the renal ward on the 16th March 2018. These first two falls were on balance unavoidable. During the second fall he sustained a large swelling to his right elbow, and on the 25th March 2018 he underwent a right elbow haematoma evacuation. On the 21st March he was transferred to the surgical ward. On the latter ward he suffered three further falls on the 6th, 7th and 12th April. The falls all occurred overnight. Mr Jones was not being nursed in a floor level bed. Following his fifth fall on the 12th April Mr Jones' neurological observations were not done in accordance with the falls protocol, and consideration was not given as to whether his anticoagulation medication should be stopped. As a result of this latter fall, Mr Jones suffered a significant head injury. There was a delay in the diagnosis of this injury. A CT head scan had been requested. However it did not occur. Approximately 19 hours after the last fall Mr Jones' conscious levels deteriorated acutely. He was then sent for urgent CT imaging at approximately 01.00 hours on the 13th April. This revealed a large right sided extra axial bleed, which was thought likely to be subdural, with a significant mid line shift. After discussion between clinicians and family members it was decided that referral for neurosurgical treatment would not be appropriate. It is probable that this clinical decision would have been the same even if his head injury had been diagnosed earlier. Mr Jones' condition steadily deteriorated. He passed away at 17.30 hours on the 13th April 2018.

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. Whether sufficient consideration is given to falls prevention measures on the surgical ward, 2. Whether there is sufficient understanding of the post falls protocol that must be followed on the surgical ward, 3. Whether there is sufficient understanding that a medical review of a patient post fall must include review of their current medications, 4. When a patient is transferred between wards, whether there is sufficient handover of safety information pertaining to a patient.
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 4pm 13th June 2019. 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] 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	Dated 18th April 2019 Signature Ms K Skerrett Senior Coroner for Gloucestershire