REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. University Hospital of Derby and Burton; 2. NHS England; 3. Chief Coroner; 4. Family of the deceased.
1	**CORONER** I am Emma Serrano, Assistant Coroner, for the coroner area of the Derby and Derbyshire.
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 12th November 2019, I commenced an investigation into the death of Mrs Maureen Ann Brown. The investigation concluded at the end of the inquest on the 3 February 2020. The conclusion of the inquest was a short narrative conclusion stating: *"On the 1 June 2019 at the Coach House, Derby Road, Milford, Belper, Derbyshire, from a subdural haemorrhage caused by a fall whilst a patient at the Royal Derby Hospital. On being transferred from MAU to ward 405 information relevant to her falls risk assessment was known, but not recorded within the electronic transfer information. As a consequence ward 405 were not made aware of information which would have led the deceased having an increased supervision care bundle".* The cause of death was: 1a Subdural haemorrhage due to; 1b Fall.
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Brown was admitted to the Royal derby Hospital on the 16th April 2019. This was following a referral from her GP. This was for a urine sample showing pseudomonas, and the need for intravenous antibiotics. She was admitted under the Medical Assessment Unit ("MAU") and transferred to ward 405. ii) Before her transfer, Mrs Browns' daughter made the staff on MAU aware that Mrs Brown was increasingly confused due to the infection and may try and get out of her bed and as such was at an increased risk of falls. In addition, she disclosed that Mrs Brown had had a previous fall whilst she was a patient at the Royal Derby Hospital. iii) When a patient is ready for transfer an electronic handover is completed by the transferring ward. This is the only information that the receiving ward have access to at the point of accepting a patient to their ward. The

	information given by the Mrs Browns' daughter, was not recorded in the electronic handover. iv) On being admitted to Ward 405 a Falls Risk Assessment was carried out, based on the information received from MAU. She was deemed to be a high risk of falls and falls preventions measures were put in place. These included bed rails and a call buzzer. She was placed onto a normal ward. However, had the information supplied by Mrs Browns' daughter been included on the electronic transfer information, Mrs Brown would have been assessed as a high Risk of falls as well as needing an Increased Supervision Care Bundle. v) An Increased Supervision Care Bundle would have meant that Mrs Brown would have been put onto a ward with only 3 other patients, rather than a full hospital ward, and there would have been constant supervision by a nurse. vi) She subsequently fell from her bed. This caused her to suffer a bleed to the brain from which, she did not recover. vii) It was accepted by the Royal Derby Hospital that had Mrs Brown been on the Increased Supervision Care Bundle, it was more likely than it was not that she would not have fallen.
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. Evidence emerged during the inquest that the electronic transfer information is the only information that the receiving ward is given before a patient is transferred. Other relevant information, that is necessary for an effective handover to take place, can be missed as the electronic transfer system limits how much information can be recorded. 2. Evidence was heard regarding the steps that the Royal Derby Hospital has made to remedy this issue. However, the national policy still states that the only piece of information necessary for a transfer is the electronic transfer information.
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. 1. You may wish to consider the NHS policy and procedures for patient transfer.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24 March 2020. 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: 1. NHS England; 2. The Chef Coroner; 3. The University Hospital and derby and Burton; and 4. The family of the deceased. 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	**04 February 2019**  **Miss Emma Serrano** **Assistant Coroner** **Derby and Derbyshire Coroners Area**