Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Executive, Aneurin Bevan University Health board
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 **19/11/19** an investigation was opened into the death of **Alan JONES** The investigation concluded at the end of the inquest on: **10/2/21** The conclusion of the inquest was recorded as: **A <u>Narrative Conclusion</u> as follows:** **Alan Jones was admitted to Neville Hall Hospital on 25th October 2019, having suffered a fall at home. He suffered from dementia and postural hypotension which increased his risk of falls. The multidisciplinary team failed to properly assess and manage his falls risk and as a result Mr Jones fell 7 times on the ward. On 13th November 2019 he fell when he should have been under constant supervision. He suffered a fatal head injury and died on 14th November 2019 in Neville Hall Hospital. His death was contributed to by neglect.** The medical cause of death was: 1a **Subdural Haematoma** 1b Multiple Falls 1c Alzheimers Dementia 2 Postural Hypotension
4	**CIRCUMSTANCES OF THE DEATH** Alan Jones was a 93-year-old gentleman whose health was in serious decline. He suffered from a number of problems and it would seem was finding it

	difficult to cope at home. He was admitted to Neville Hall Hospital on 25th October 2019 after suffering a fall at home. Mr Jones' condition did not appreciably improve and on 13th November 2019 he fell on the ward when he should have been in receipt of 1:1 supervision. He suffered a fatal head injury and died in Neville Hall Hospital the following day.
5	**CORONER'S CONCERNS** During the course of the inquest, 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: - <u>Multidisciplinary Care</u> Mr Jones' level of confusion and his agitation appears to have increased during his admission and yet I have seen no evidence of a truly multidisciplinary approach to how this should be managed. The risk assessment is multifactorial but the evidence presented suggested that care lies wholly within the nursing domain. Throughout this time, Mr Jones was clearly in the highest category of falls risk, he was confused, agitated, unsafe on his feet and yet there is no evidence that nurses and doctors and physios and pharmacists met together to discuss how these problems would be managed. The fact that during Mr Jones's hospital stay from 25th October 2019 to his death on 14th November 2019 he fell 7 times and the last time resulted in his death, demonstrates a complete failure in the falls prevention strategy at ABUHB. <u>1:1 Supervision</u> Throughout Mr Jones' admission I heard evidence that he required either 1:1 supervision (Enhanced Care Level 5) or to be supervised in a cohorted bay (Enhanced Care Level 4). This level of care was not achieved and as a result within less than 3 weeks of his admission, Mr Jones had fallen on 7 occasions, at times as a direct result of a failure to provide adequate supervision. I am satisfied that the nursing staff were aware of the level of supervision required and regularly requested additional nursing support. These requests were not resourced. It appears that the nursing staff had become used to this situation and tried to do the best they could in the circumstances. It also appeared that a ward which cares for patients who are the most likely to require extra support because they are confused, elderly and at risk of falls, is staffed to a minimum level which does not take account of any fluctuations in acuity.

	Of concern was that despite hearing evidence that improvements in falls management had been introduced, I also heard evidence that nursing staff on the ward continue to find themselves nursing with unsafe levels of staff.
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. <u>I should be grateful if the following information be provided to me:</u> 1. Confirm whether any steps have or will be taken to ensure a truly multidisciplinary approach to managing patients' needs when they are at high risk of falls. 2. Set out the steps taken to ensure that patients are not put at risk through the inadequate staffing of a ward which routinely cares for the elderly and vulnerable.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 13/4/21. I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) . The family of Alan Jones 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 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	**DATE 16/2/2021** Signed  Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**