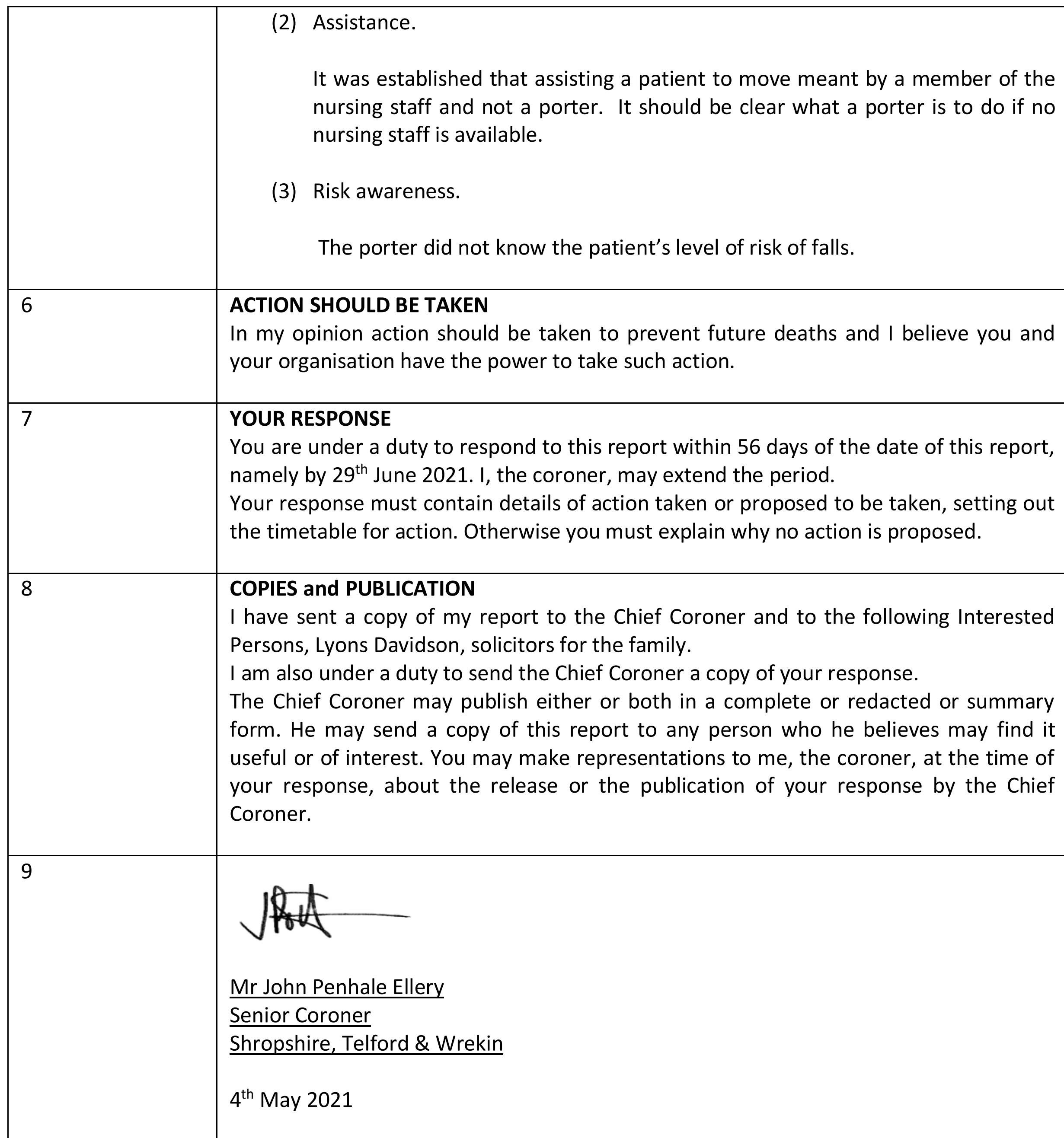
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive, Shrewsbury and Telford Hospital Trust
1	**CORONER** I am Mr John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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 16th October 2020 I commenced an investigation into the death of the late William Arthur John SIMONS, 93 years of age. The investigation concluded at the end of the inquest on the 20th and 27th day of April 2021. The conclusion of the inquest was that the deceased died following two falls the second of which was the more significant and preventable.
4	**CIRCUMSTANCES OF THE DEATH** Mr Simons was admitted to the Royal Shrewsbury Hospital by his GP on the 21st August 2020 where he stayed undergoing treatment. Before that treatment was completed there were two intervening events which caused or contributed to his death. The first was a fall on the 23rd August 2020 on Ward 22 F when he fell having been to the toilet. The nurse who escorted him waited outside but was called away to another patient. Mr Simons having finished left the toilet without using the call bell. He was found lying on the floor. It was later discovered he had fractured his hip and underwent surgery. On the 8th September 2020 then on Ward 22 T&O Mr Simons had a further fall when he was returned to his bed having been taken by wheelchair for a Doppler scan on his left leg. On returning Mr Simons to the ward no one was available and the porter assisted Mr Simons without a nurse. Mr Simons walked about 2 meters with his zimmer frame but lost his balance and fell back hitting the back of his head on the floor. Both falls contributed to his death with the second the more significant of the two.
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) The Tele-tracking system a) It was not clear what the purpose was of a doctor expressing a preferred option of transport (i.e. by trolley/bed) if that doctor did not have sufficient information to make it. b) Whilst it became clear that that option was subject to review by the nursing staff on the ward it was not clear why a doctor would not either liaise with the nursing staff or expressly make it clear that the nursing staff should make that assessment and inform the porters accordingly. c) The system on the day led to confusion and a breakdown in communication with the patient being taken instead by wheelchair with his zimmer frame.



	(2) Assistance. It was established that assisting a patient to move meant by a member of the nursing staff and not a porter. It should be clear what a porter is to do if no nursing staff is available. (3) Risk awareness. The porter did not know the patient's level of risk of falls.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 29th June 2021. 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, Lyons Davidson, solicitors for the family. 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	Mr John Penhale Ellery Senior Coroner Shropshire, Telford & Wrekin 4th May 2021