**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. The Chief Executive of Northumbria Health Care Trust** |
| 1 | **CORONER**<br><br>I am Carly Elizabeth Henley, Assistant Coroner, for the coroner areas of Newcastle upon Tyne and North Tyneside. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 6th July 2021 I opened an inquest into the death of Benjamin Clark.<br><br>On 8th July 2021 I resumed the inquest, hearing oral evidence. I concluded that Mr Clark died an accidental death having suffered a series of falls which resulted in Acute on Chronic Subdural Haematomas and mass effect on the brain. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Benjamin Clark (born 14/04/1933) died at North Tyneside General Hospital on 17th January 2021 aged 87 years old.<br><br>He had been admitted to North Tyneside General Hospital on 6.11.20 having suffered a series of unwitnessed falls at home. On 21.11.20 he suffered a fall on the ward in North Tyneside Hospital. A CT scan of the brain showed that he had suffered Acute on Chronic Subdural Haematomas. He did not recover from these injuries and ultimately died in hospital. |
| 5 | **CORONER'S CONCERNS**<br><br>During 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.<br><br>The **MATTERS OF CONCERN** are as follows. – |

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| | 1. I heard evidence from Matron [redacted] who carried out a Root Cause Analysis following Mr. Clark's fall in hospital. She told me that despite Mr. Clark having been assessed to be a Level 3 Risk of Falls in Northumbria Specialist Emergency Care Hospital (NSECH), when he was transferred to North Tyneside General Hospital his falls risk was downgraded to Level 2 without any notes being provided to justify this reassessment.<br><br>2. Matron [redacted] told me that at the time of the fall, Mr. Clark was under observation as though he was a Level 1 falls risk, despite being assessed as Level 2. Note keeping was suboptimal and there was a lack of clarity as to whether he should have been observed every 30 minutes or every 60 minutes.<br><br>3. The Avoiding Falls Level of Observation Assessment Tool (AFLOAT) was used in both hospitals but only NSECH evidenced use of this tool in writing. Observational charts were not in use in North Tyneside General Hospital. Matron [redacted] told me that every patient should be reassessed every day and following any significant change in presentation. There was a lack of written evidence at North Tyneside General Hospital to demonstrate that this had been done in Mr. Clark's case. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th August 2021. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br>Mr Clark's family |

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| | I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **08.07.2021** **C E HENLEY** |
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