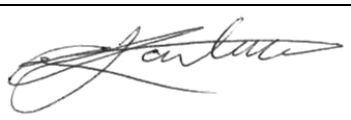
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **Princess Royal University Hospital** **Farnborough Common** **Orpington**
1	**CORONER** I am Jonathan Landau, assistant coroner for the coroner area of South London
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 24 March 2021, an investigation into the death of Hazel Fleur Wiltshire was opened. The investigation concluded at the end of the inquest on 4 August 2021. The conclusion of theinquest was a narrative conclusion as follows: "Mrs Wiltshire died from pneumonia caused by a fall and by Covid 19 that she acquired in hospital. The fall was caused by her trying to relieve herself without assistance in the context of long delays in answering calls bells at the time"
4	**CIRCUMSTANCES OF THE DEATH** Mrs Hazel Fleur Wiltshire was admitted to the Princess Royal University Hospital on 14 January 2021 following a fall at home. Although she had a number of factors indicating a risk of further falls, no risk assessments were completed on three wards and there was no evidence that measures that could mitigate the risk of falls were considered. Mrs Wiltshire's toileting care plan indicated that she was to be assisted with her toileting needs and she had access to a call bell. However, there were lengthy delays in responding to the call bell and on the night of 22 January 2021 she tried to relive herself without assistance which caused her to fall. She died in hospital on 19 February 2021 from pneumonia caused by the fall and by Covid 19 that she acquired in hospital.

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 could 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 matron who gave evidence was not aware of obtaining data on response times from the call bell system and had not introduced any other system to monitor response times. (2) Staffing levels were inadequate due to higher dependency of patients with Covid. I heard that one patient had to soil herself in her hand as no one was available to assist her with her toileting needs. Mrs Wiltshire phoned home on occasion to ask her family to call the ward because they were not responding to her call bell. The family could hear other patients on the ward crying out for help. (3) Although Mrs Wiltshire was at risk of falls, no risk assessments were completed on any of the three wards in which she stayed. This suggests a systemic problem across the hospital that requires remedial action.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe youyour organisation has 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 26 October 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 am under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. In this case, I have sent the report to Mrs Wiltshire's daughter. 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.
9	 **Jonathan Landau, HM Assistant Coroner**

	1 September 2021