	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Maria Caulfield MP Parliamentary Under Secretary of State (Minister for Patient Safety and Primary Care) C/OMinisterial Correspondence and Public Enquiries Unit Department of Health and Social Care 39 Victoria Street London SW1H 0EU
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** The death of **Barrie Keith Housby** on 13-07-2021 at Blackpool Victoria Hospital was reported to me and I opened an investigation, which concluded by way of an inquest held on 9th & 10th November 2021. I determined that the medical cause of Mr. Housby's death was **1 a Traumatic Subdural Haemorrhage following a fall.** In box 3 of the Record of Inquest I recorded as follows: Barrie Housby had a medical history that included frailty, Parkinson's disease, macular degeneration, and had recently been prone to falling. His hearing and vision were also compromised. On 1 July 2021, he was transferred to Clifton hospital for a period of rehabilitation. He was known to be at high risk of further falls. Whilst in hospital he could be confused and agitated, in part because he would not always accept medication prescribed for his Parkinson's disease. He was known to make attempts to climb out of his hospital bed and had been assessed as requiring observation by a member of staff on a one to one basis. His condition was regarded as improved during 10 & 11 July 2021 when he appeared lucid and plans were being considered for his discharge from hospital. At the commencement of a nightshift on the evening of 12/07/21, care staff were reminded that he was to be nursed on a one to one basis and staff should not leave his bay unattended. Shortly afterwards, he wandered unobserved from his bed and had to be returned to his bed by health care assistants. This was not brought to the attention of nursing staff. At around 2255 hours, with Barrie seemingly settled in bed, a member of staff allocated to monitor him left his bay to attend to other duties that she had not

	performed by that time, in part due to a shortage of staff. She intended to return a short time later. Before she could do so, Barrie left his bed and was heard to fall to the floor. Staff entered the bay and went to his aid, but he was found unresponsive. His level of consciousness significantly reduced, he was transferred to a hospital Emergency Department by ambulance. A CT scan revealed he had received a catastrophic brain injury. Barrie died at 10.45 hours on 13 July 2021. Had a member of staff remained on the bay with Barrie at all times he would probably not have been able to leave his bed and suffer a fall. The conclusion of the Coroner was one of **Accidental death**.
4	**<u>CIRCUMSTANCES OF THE DEATH</u>** In addition to the contents of section 3 above, the following is of note: • Mr. Housby had been admitted to hospital after reported falls at his home. It was clear to all that he was a very challenging patient in terms of minimizing the risk of a fall and an appropriate decision had been made that he was to be monitored by way of 1:1 nursing. • That prior to the start of the night shift during which Mr. Housby suffered the fall which would prove to be fatal, a decision had been made to reduce the number of staff working that shift due to unexpected staff absences. This meant that staff were redistributed around the hospital. • This reduction clearly had an impact on the staff who remained on the ward within which Mr Housby was located. Given the number of patients. And the various challenges they posed in terms of their needs, there was a shortage of staff. • That the evidence is clear that a Health Care Assistant had been told that as Mr Housby was being nursed on a 1 to 1 basis she should not leave his bay. Notwithstanding this instruction, she did leave the bay – this was to perform a task which ideally she would have performed earlier in the evening. It was not an urgent task. She left the bay at a time when she felt Barrie was settled. I accepted that she only intended to be off the bay for a couple of minutes or less. • The court heard that had any member of staff on the bay that staff member would have been able to reach him in time had they become aware he was trying to leave his bed. • That staffing levels did contribute to this incident. The HCA's decision to leave the bay was affected by the reduction in staff because she felt there were duties she ought by that point in the shift have completed but these remained outstanding because there had because she had been so busy during the shift up to that point as a direct result of the staff shortage.
5	**<u>CORONER'S CONCERNS</u>** 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. –

	The court received some helpful evidence from a Clinical Matron at the hospital. She explained that since Mr Housby's death changes have been made which have included a new Trust policy. (It should also be noted that there was some good practice noted in relation to Mr Housby's care.) However, it was not disputed there are long – standing challenges in terms of staffing levels, notwithstanding efforts that have been and continue to be made in relation to recruitment of new staff. However, during this inquest the hospital staff could not have been clearer in their views: do to the reduction in staff numbers, they did not have enough time to carry out their expected tasks. As one HCA told the court, it was "impossible" to provide one to one nursing care to Mr Housby with the number of staff working that shift at that time. The court was told that since Mr Housby's death, the problem of staffing shortages persists. My concern therefore is as follows: Clifton hospital is a place to where patients – often elderly and vulnerable – are transferred for a period of rehabilitation, usually from an acute hospital setting. The aim usually is that following such rehabilitation they can hopefully return to their homes, or perhaps be discharged to a suitable care home. However, these patients are being put at risk due to a shortage of staff. As Senior Coroner for this coronial area, I have considered what options are available. It seems to me that Blackpool Teaching Hospital NHS Foundation Trust is very much aware of the issue, and are trying to resolve it and that the ongoing efforts to recruit is very much part of this. However, the risk to patients persists, and I feel it would be remiss of me not to write this letter in order to further highlight the problem. Blackpool is an area that can face difficulties attracting and retaining staff. It seems to me that the hospital Trust needs more support as they try to remedy this problem. When a Coroner writes a report such as this one, it is not for the Coroner to be prescriptive about what ought to be done about the issue, but to raise the concern with the relevant individual and / or organisation who may be able to address this. Given your position as Parliamentary Under Secretary of State (Minister for Patient Safety and Primary Care), I forward this report to you for your consideration.
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.
7	**YOUR RESPONSE**

	You are under a duty to respond to this report within 56 days of the date of this report. Given the approaching holiday period I have extended this period to **Friday, 14th February 2022**. I, the coroner, may extend the period further. 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: • [redacted] [Daughter of Deceased] • Blackpool Teaching Hospitals NHS Foundation Trust • Blackpool Clinical Commission Group / Fylde & Wyre Clinical Commissioning Group 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	22/11/2021 Signature  Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**