REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Professor Andy Harvy, Chief Executive, University Hospitals Coventry and Warwickshire NHS Trust (UHCW), University Hospital, Clifford Bridge Road, Coventry**
1	**CORONER** I am R Brittain, Assistant Coroner for Coventry.
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** George Watson died on 21 October 2014, aged 84 years, from a subdural haemorrhage, skull fracture and compound fracture of his left humerus. An inquest into his death was opened on 28 October 2014 and ultimately reheard before a jury on 15 to 17 August 2016. The jury recorded a narrative conclusion based on a questionnaire, which included that Mr Watson's death was contributed to by neglect (see attached).
4	**CIRCUMSTANCES OF THE DEATH** Mr Watson was admitted to UHCW on 13 August 2014, following a fall at his assisted living accommodation. He fractured his collar bone which meant that it would unsafe to discharge him to his previous residence. Mr Watson was assessed as being at high risk of falls and was, for a time, nursed in a 'cohorted bay'. This meant that a member of staff was present within the bay to supervise the four patients within this area. UHCW asserted at the inquest that, at some point (mostly likely 31 August), this level of supervision was downgraded to a normal level. This would equate to one-hourly or two-hourly 'intentional rounding' checks on Mr Watson. There was no documentation of the decision to alter the supervision level. On the night shift of the 2-3 September 2014, the jury heard evidence that two registered nurses were present on Mr Watson's ward, along with one student nurse. There were also intended to be three Healthcare Assistants (HCAs) but one staff member did not attend for the shift. This third HCA was supernumerary as the normal ward requirements were for only two to be present. It was not clear from the evidence as to what role this HCA was due to be fufilling, nor was it apparent what steps were taken to address that the staff member did not attend. The jury heard evidence that the registered nurse for Mr Watson's bay on this night,

	although now retired, worked permanent night shifts. It became apparent from her evidence that she was not aware of the term 'cohorted bay' supervision and had no memory of a change in the supervision provided to Mr Watson. Documentation demonstrated that Mr Watson was checked through intentional rounding during the night of 2-3 September. However, other paperwork providing conflicting information as to whether some of these checks occurred and also what resulted. At approximately 04:30 on 3 September, Mr Watson fell from his bed and suffered the injuries which resulted in his death. UHCW accepted that the rails were raised on his bed, which should not have been the case and that this caused or contributed to his death. Mr Watson was deemed to be unfit for surgical treatment of his injuries and, on 16 October 2014, he was discharged to a palliative bed at a Nursing Home. UHCW accepted he was not discharged with necessary oral pain relief (to supplement a continuous morphine infusion that was prescribed). The 'Do Not Resuscitate' form that had been completed during his in-patient admission, was also not provided to the Nursing Home. On 21 October 2014, Mr Watson's death was pronounced. A *post mortem* was undertaken and the pathologist raised concerns to the police regarding the nature of the injuries present. The Nursing Home and General Practitioner also raised concerns to the Care Quality Commission. UHCW undertook an investigation into the circumstances of Mr Watson's fall. The police also investigated possible criminal charges arising from his death and raised concerns that UCHW's lack of coooperation hindered the progress of police inquiries. UHCW accepted that their internal investigation was unsatisfactory. I heard evidence that steps have been taken to improve the investigatory process, such as having a 'post-fall huddle', including relevant staff at initial meetings into an incident and involving the Trust's Health and Safety Officer at an early stage in the investigation.
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) UHCW acknowledged that Mr Watson's discharge did not proceed satisfactorily. However, no evidence was provided as to what steps have been taken to address this issue. In particular, it is not clear whether the risk that patients are discharged without appropriate medication has been addressed. (2) Issues around staffing allocation and resourcing were discussed in detail at the inquest. It remained unclear how, when additional resources were recognised as being required, these staff members were 'labelled' as being needed for a specific purpose. Futhermore, it was not clear what steps should be taken when the staff member does not attend, or is not available. (3) The ability of UHCW to monitor and assess staff who work on permanent night shifts was raised at the inquest. Evidence was adduced that this issue is being considered at present but it was unclear whether steps have been, or will be taken to address this issue. (4) Although UHCW provided oral evidence regarding some steps that have been taken to improve its investigatory processes, given the signficance of the issues that were raised, I believe it is necessary to ask the Trust to confirm these in writing and provide further

	evidence that it has addressed the issues that arose in the investigation of this case. In particular, the need to cooperate with police investigations was noted to be a learning point for one witness but wider learning for the Trust as a whole was not adduced in evidence.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressee, 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 14 October 2016. 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, Mr Watson's family, [redacted] General Practitioner and the Care Quality Commission. 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	**19 August 2016**  **Assistant Coroner R Brittain**