Regulation 28: REPORT TO PREVENT FUTURE DEATHS

.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Chief Executive
Norfolk and Norwich University Hospital
Colney Lane
Norwich
NR4 7UY

1. CORONER

I am Jacqueline LAKE, Senior Coroner for the area of Norfolk

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 26/07/2021 I commenced an investigation into the death of Irene Muriel FITCHES aged 77. The investigation concluded at the end of the inquest on 11/02/2022. The medical cause of death was:

1a) Subdural Haematoma
1b) Fall
1c) Benign Positional Paroxysmal Vertigo
1d)
2 Type 2 Diabetes, Hypertension, Mild Cognitive Impairment

The conclusion of the inquest was: Accident.

4. CIRCUMSTANCES OF THE DEATH

Mrs Fitches had a significant past medical history. On 17 July 2021 Mrs Fitches was admitted to Norfolk and Norwich University Hospital due to dizziness, nausea and being generally unwell. Mrs Fitches was diagnosed with Benign Positional Paroxysmal Vertigo and a management plan was put in place. Mrs Fitches was considered medically fit for discharge. On 21 July 2021 Mrs Fitches had an unwitnessed fall in her room and suffered a head injury. Her condition deteriorated and she became unresponsive. Mrs Fitches died on 22 July 2021.

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 present Falls Policy does not comply with NICE Guidelines.
2. Evidence was heard that a Falls Policy was drafted, and a Risk Assessment trialled at the beginning of 2020, the Covid-19 pandemic intervened and delayed its completion.
3. There is no person appointed as Falls Lead. The job application has not yet been advertised, although it is recognised that someone is required to lead the Falls process.
4. Staff will need training and the training package has not yet been developed.
5. Assisted Technology is being considered to alert staff to movements and the needs of patients. This has not been progressed since October 2021 and is still at an early stage.

6. ACTION SHOULD BE TAKEN

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

You are under a duty to respond to this report within 56 days of the date of this report, namely by 14 April 2022. 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:

The family of Mrs Fitches, via their solicitor.

I have also sent it to:

- The Department of Health
- Care Quality Commission (CQC)
- HSIB
- Healthwatch Norfolk
- NHS England & NHS Improvement

who may find it useful or of interest.

I am also 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.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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. Dated: 18 February 2022

Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
County Hall
Martineau Lane
Norwich NR1 2DH