Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. The Chief Executive of Aneurin Bevan University Health Board
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 **10/2/21** an investigation was opened into the death of **Marvin John RUE** The investigation concluded at the end of the inquest on: **24/2/22** The conclusion of the inquest was recorded as: **A narrative conclusion in the following terms:** *Marvin Rue was admitted to hospital on 8th January 2021. He was confused and suffering from type 2 respiratory failure. Mr Rue fell prior to admission to hospital, and he fell 5 times in hospital but there was a failure to undertake a comprehensive or correct assessment of his falls' risk. As a result there was a failure to provide Mr Rue with the correct level of supervision. On 2nd February 2021 Marvin Rue fell again and suffered a fatal head injury which resulted in his death on 3rd February 2021 at the Grange University hospital.* *Marvin Rue's death was caused by an accident contributed to by neglect.* The medical cause of death was: 1a **Right-sided subdural haematoma with midline shift** b **Occipital bone fracture** c **Fall**

4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Marvin Rue's death are set out in the narrative at Paragraph 3.
5	**CORONER'S CONCERNS** During the course of the inquest, 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: - Marvin Rue had fallen prior to his admission to hospital on 8th January 2021 and was therefore, due to his age and circumstances, a "known falls risk". In evidence I heard that in these circumstances a Multifactorial Risk Assessment (MFRA) should take place within 6 hours of admission to hospital. It was not. Mr Rue was transferred between hospitals during his admission, initially to Nevill Hall Hospital and then to Ysbyty Aneurin Bevan. I heard in evidence that a review of the MRFA should take place after every hospital transfer. Mr Rue had no MFRA undertaken after his transfers. Mr Rue fell 5 times prior to his fatal fall in hospital on 2nd February 2021. Contrary to Health Board Policy, Mr Rue did not have an MFRA undertaken after any of these falls. In fact there was never an MFRA correctly completed for Mr Rue throughout his hospital admission. I heard evidence that during this time the staff were under significant pressure due to the effects of the pandemic, and I accept that. However the care that Mr Rue was denied was basic nursing care. [redacted] the Lead Nurse and author of the Serious Concerns Report, indicated that had Mr Rue been assessed, he would have warranted 1:1 supervision . As a result I concluded that the failures in care directly contributed to Mr Rue's death. During the inquest I was presented with an action plan, however this is not the first action plan I have been presented with (in very similar circumstances) and sadly I am not convinced that this plan will prevent future deaths for the following reasons. The policies referred to above have been in place for several years. I am informed that although there is bespoke documentation training, all staff are trained in falls risk assessment from the time they are in nurse training. Therefore it is not a lack of understanding or policies which have caused these failures. None of the staff were interviewed during the internal investigation and no evidence was forthcoming as to **why** staff did not follow the procedures. Without this information I do not consider that the actions plan will prevent

	future deaths. I refer you to your previous responses to PFDs which have clearly not had the desired outcome. Despite being previously reassured that regular ward audits would take place to ensure that the risk assessments were being undertaken I heard no evidence that audits were completed at this time and so the failures went unnoticed until after Mr Rue's death.
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. <u>I should be grateful if the following information be provided to me:</u> 1. The action that will be taken to address the reason why staff are failing to follow the policies as indicated by their training. 2. Reassurance that Senior Management within the Health Board is fully aware of the risks posed to patients through regular monitoring of adherence to the Falls Policy. 3. A revised action plan which takes points (1) and (2) into account.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **28 April 2022**. I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) The family of Marvin Rue Health Inspectorate Wales. 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 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	**DATE 3 March 2022** Signed  Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**