David Ll. Roberts LL.B

Her Majesty's Senior Coroner

North and West Cumbria

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **RE: Wilhelmina Isobel Newton Deceased** **THIS REPORT IS BEING SENT TO:** **1. Mrs Diane Wood Chief executive Cumbria County Council Carlisle** **2. [redacted] Corporate Director Adult and Local services Cumbria County Council Carlisle**
1	**CORONER** I am David Ll. Roberts, senior coroner, for the coroners area of North and West Cumbria
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 13th May 2013 I commenced an investigation into the death of Wilhelmina Isobel Newton, 98. The investigation concluded at the end of the inquest on 21st October 2013. The conclusion of the inquest was Medical cause of death 1a) Subdural Haematoma b) Fall Conclusion: On the 14th May 2013 in her room at Grisedale Croft Residential Home the deceased was put into bed at about 03.00 hrs. At 04.30 hrs she shouted and was found to be lying on the floor next to her bed. Later that morning she was found to be unrousable and was admitted to Cumberland Infirmary where she died on 15th May 2013. She died as the result of an Accident.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of falls both before and after becoming a resident at Grisedale Croft. She had fallen out of bed and banged her head at 04.30 hours. She was not attended by a nurse until 09.45 hours shortly after which an ambulance was summoned. She was prescribed regular aspirin.

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. – On the evidence heard it appeared there was no clear written plan , protocol or guidance to the staff as to how they should respond to a potential head injury to an elderly resident, particularly one receiving medication which had the potential to affect the blood's clotting ability: the absence of such guidance may apply to other residential homes operated by the Council
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, by way of a review of the procedures to be followed when a resident is suspected of sustaining a head injury particularly when that person is prescribed medication which affects the blood's ability to clot.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th December 2013. 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 :- [redacted] The Chairman, The Adult Safeguarding Board Public Protection Unit, Cumbria Constabulary 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	**31st October 2013** **D. LL. Roberts** **HM Senior Coroner**