ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **Corporate Director, Dovecote Lodge, Dovecote Lane, Horbury.**
1	**CORONER** I am Mary Burke, Assistant Coroner, for the coroner area of West Yorkshire (Western)
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 19th September 2013 I commenced an investigation into the death of Edna Bulmer, aged 87 years. The investigation concluded at the end of the inquest on 25th June 2014.The conclusion of the inquest was a narrative conclusion in the following terms: "Edna Bulmer had a medical history of atrial fibrillation hypertension and stroke. In July 2013 she suffered a further stroke and was admitted to hospital and prescribed the anticoagulant medication Warfarin. Prior to hospital discharge a decision was taken to change her anticoagulant medication to Apixaban, which she commenced on 9 September 2013. The following day she suffered an unwitnessed fall and suffered an apparent minor head injury with laceration to the back of her head. She was reviewed in the accident and emergency department at Pinderfields General Hospital where she showed no sign of any compromise to her neurological state. Her treating clinicians were unaware that Mrs Bulmer was taking Apixaban. The laceration was sutured and she was discharged from hospital. During the early hours of 12 September 2013 Mrs Bulmer was found unconscious in bed. She was admitted to Dewsbury and District Hospital where she died at 23:30 hours on 15 September 2013 as a result of a large left sided subarachnoid haematoma which she had sustained as a result of her fall on 10 September. The combined administration of Apixaban following her fall and her underlying atrial fibrillation were likely to have contributed to her death", the medical cause of death being: 1(a) Large left sided subdural haematoma due to 1(b) Head injury secondary to fall and 11. Atrial fibrillation. Stroke.
4	**CIRCUMSTANCES OF THE DEATH** Edna Bulmer had a medical history of atrial fibrillation, hypertension and stroke. Her balance was poor and she suffered from recurrent falls. In July 2013 she suffered a further stroke and was admitted to hospital and later prescribed the anti coagulant warfarin. Whilst in hospital Mrs. Bulmer continued to suffer falls. On 6th September 2013 Mrs. Bulmer was thought to be medically fit for discharge and

	transferred to Dovecote Lodge. Prior to hospital discharge a decision was taken to change her anti coagulant medication to Apixaban, which she commenced on 9th September 2013, three days following her arrival at Dovecote Lodge when her INR blood levels had reduced appropriately. Before Mrs. Bulmer was transferred a member of staff from Dovecote Lodge undertook an assessment upon Mrs. Bulmer which is recorded within the written records of the unit. The risk of falls has been recorded within the records as both high and very high. As part of the assessment a Personal Risk Assessment Form was completed and dated 4th September 2013, and it appears that additional comments were added on the 6th September 2013 (the day of Mrs. Bulmer's arrival at Dovecote Lodge). The additional entry states that a pressure mat be placed at the side of Mrs. Bulmer's bed and also that Mrs. Bulmer should be provided with a pendant so that she could call for assistance at any time. On the 6th September and the 8th September she appears to have slipped/fallen from her bed, on both occasions such incidents were unwitnessed. I heard evidence from [redacted] Assistant Manager at the home. I drew to her attention that on the second page, Section 6, Action Taken, of the Incident Report form dated the 8th September 2013, it states "pressure mat put in place, already identified as high risk of falls, pendant given to Mrs. Bulmer to alert staff if she needs assistance." This entry clearly suggests that a mat and pendant had not been provided up until this point despite the requirement being identified within the Personal Risk Assessment document. [redacted] was unable to explain why or shed any further light on this point. I raised with her what systems were in place to review a Personal Risk Assessment Document and in particular what would "trigger" a review. She was unable to provide me with a clear answer. On 10th September 2013 Mrs. Bulmer suffered a further unwitnessed fall. She was taken to hospital and later discharged that day. She remained on her anti coagulant medication. During the night of the 12th September 2013 Mrs. Bulmer was found unconscious in bed. She was readmitted to hospital and was found to have suffered an acute left-sided subdural haemorrhage. The evidence presented at inquest that it had been caused as a result of her fall on the 10th September 2013.
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 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) There did not appear to be a clear identification of the level of risk of Mrs. Bulmer falling made within Dovecote Lodge records. In one section Mrs. Bulmer is described as very high risk, elsewhere she is described as high risk. (2) The measures identified within the Personal Risk Assessment to minimise risk were not implemented (provision of mat and pendant) until several days after Mrs. Bulmer's arrival, after a number of incidents had occurred. (3) There did not appear to have been a review of the risk assessment after further fall incidents. Is there a system in place which requires a further review of the Personal Risk Assessment? If so, who has responsibility to undertake such a review? If such system does exist has it been effectively communicated to all staff members, including

	management?
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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, namely by 22nd September 2014 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 [redacted] the son of the deceased. 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	**25th July 2014**