REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Manor Park Residential Home, Green Street, Holt, Wrexham**
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and Central)]
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 the 18th of March 2014 I commenced an investigation into the death of Sybil Roberts (DOB 03.09.24, DOD 15.03.14). The investigation concluded at the end of the inquest on the 4th of September 2014. The conclusion of the inquest was that of an Accidental Death and the medical cause of death was 1(a) Right Lower Lobe Pneumonia 2 Fractured Right Neck of Femur (Operated)
4	**CIRCUMSTANCES OF THE DEATH** The Deceased fell in her care home on the 30th of December 2013 and then again on the 1st of February 2014 sustaining a fractured hip on each occasion and these injuries contributed to her subsequent death at the Maelor Hospital Wrexham on the 15th of March 2014.
5	**CORONER'S CONCERNS** During the course of the investigation it became apparent that although Mrs Roberts had been assessed upon her admission to the residential home, there had not been a referral to her GP (as would be normal practice at this home) for a further falls risk assessment. This is despite an acknowledgement that her condition was declining prior to the first fall. Furthermore her care plan and falls risk had not been reassessed and updated prior to her return to the home from hospital after the first fall and she sustained her second fracture only two days later. The **MATTERS OF CONCERN** are as follows :- An inadequate assessment of the mobility of Mrs Roberts was made and I feel it is necessary to bring this to your attention due to the fragile and vulnerable nature of other patients cared for at the home for whom an injury in these circumstances could result in death.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 7th November 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 the following Interested Persons – [redacted] (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	**[DATE] 12th September 2014 [SIGNED BY CORONER]**