Nicola Jane Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive** **Rotherham MBC Riverside House Main Street Rotherham S60 1AE**
1	**CORONER** I am Nicola Jane Mundy, Senior Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12/06/2013 I commenced an investigation into the death of Phyllis Broomhead, 90. The investigation concluded at the end of the inquest on 06 July 2015. Cause of death: Traumatic left sided subdural haemorrhage The conclusion of the inquest was a Narrative conclusion: Phyllis Broomhead became a resident at Lord Hardy Court in December 2012 due to her dementia and general care needs. Despite multi-agency support she continued to suffer falls between 11 February 2013 and the time of her death. Three of these falls led to significant injuries. On 9 June she fell from her bed whilst trying to reach the toilet and sustained a head injury from which she died later that day
4	**CIRCUMSTANCES OF THE DEATH** Mrs Phyllis Broomhead suffered from advanced brain disease (dementia) as a consequence of which she was admitted to the Lord Hardy Court EMI Residential Home on the 18th December 2012. The home cared for her general care needs and her dementia needs. Despite multi agency input Mrs Broomhead suffered several falls between the 11th December 2013 and her death on the 9th June 2013. Of the falls she suffered three of them were significant and all required hospitalisation. A Safeguarding Alert was raised at the time of the second significant injury which was exited the day of the alert, after enquiries had been made. It was felt all appropriate measures were in place and Mrs Broomhead returned to Lord Hardy Court. The falls continued until final fatal fall on 9 June 2013. Measures in place were not fully implemented.
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: – (1) Staff employed at Lord Hardy Court EMI Residential Home require further training with regard to: i. the head injury protocol, how this should be followed and the importance of doing so.

	ii. record keeping. iii. indicators and triggers to seek social worker input. (2) With regard to the Safeguarding team, subject to the impact of any subsequent legislation, the importance of ensuring that any initial screening process following a referral is sufficiently detailed and objective to facilitate the making of safe, sound and informed decisions with regard to any future action which might be indicated or indeed before exiting the process. Furthermore, I heard evidence that there were three types of home available; care homes, EMI care homes and nursing homes. For residents who are clearly continuing to be at high risk of serious injury, as was the case here, consideration should be given to introducing or expanding any local procedures or protocols to ensure closer scrutiny and monitoring of such residents' progress. It seemed that although Mrs Broomhead was identified as being of high risk of falls, as it was felt that her needs didn't amount to nursing needs there was no alternative but for her to remain in a care home.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you The Chief Executive, Rotherham Metropolitan Borough Council 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 31 August 2015. 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]. I have also sent it to Messrs Kennedys solicitors and Capsticks solicitors - who may find it useful or of interest. 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	Dated 06 July 2015 Signature [redacted] Senior Coroner for South Yorkshire (East District)