REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ranc Care Homes Ltd**
1	**CORONER** I am Patricia Harding, senior coroner for the coroner area of Mid Kent & Medway
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 15th July 2015 I commenced an investigation into the death of Lilian Hursell, 94 years. The investigation concluded at the end of the inquest on 29th March 2016. The conclusion of the inquest was that Lilian Hursell died as the result of an accident
4	**CIRCUMSTANCES OF THE DEATH** Lilian Hursell died on 6th July 2015 at Pembury Hospital from pneumonia contracted as a result of immobility contributed to by unstable fractured cervical vertebra occasioned as a result of a fall from bed on 30th June 2015 at Maidstone Care Centre when cotrails had been lowered in order to provide personal care and the provider of that care was not positioned at the bedside so as to prevent the fall occurring
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) The mechanism to hold the cotsides (bedrails) in a vertical position comprise a retaining button in a sliding vertical rail which engages with a corresponding hole in a static rail. Whilst this mechanism operates safely when the mechanism is properly engaged which is established by an audible click, staff at the care home had experienced occasions when the cotsides retaining button had not been fully engaged when the cotside had been raised to prevent a resident falling from the bed rendering the cotside unstable and at risk of lowering inadvertently. (2) Nursing and healthcare staff moved a patient onto her back and placed a pillow under her head when the patient had suffered a significant uncontrolled fall onto

	her face and the extent of her injuries had not been assessed. It was known at the time that this happened that she had suffered a head trauma as she had a bleeding injury to her forehead, she had however additionally suffered a subdural haematoma and had fractures to her cervical vertebra
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st June 2016. 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] daughter, [redacted] nurse, South East Coast Ambulance Service. I have also sent it to Care Quality Commission 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	**1st April 2016** **[SIGNED BY CORONER]**