REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Manager, Rosedale Care Home**
1	**CORONER** I am Clare Bailey, acting senior coroner, for the coroner area of Teesside.
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 1 December 2015 I commenced an investigation into the death of Margaret Jane METCALFE. The investigation concluded at the end of the inquest on 14 March 2016. The conclusion of the inquest was ACCIDENT including medical cause of death of Acute and Chronic Subdural Haemorrhage with contributory factors of Congestive Cardiac Failure and Ischaemic Heart Disease.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Metcalfe sustained a fall whilst resident at Rosedale Care Home on 25 October 2015. She was transported to the University Hospital of North Tees where she passed away on 23 November 2015.
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. – Mrs Metcalfe had requested help from staff by pressing a hand held buzzer. Her bed had been fitted with a specialist alarm that should have alerted staff that she had got up out of bed. For unknown reasons staff were not alerted by either the hand held buzzer or bed alarms but instead were alerted by hearing a "thud" in the corridor when Mrs Metcalfe fell.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 9 May 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] 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 – 14 March 2016** **[SIGNED BY CORONER]**