	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Templemore Care Home** **Northampton General Hospital**
1	**CORONER** I am Hassan SHAH, Assistant Coroner for the coroner area of Northamptonshire.
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** Mrs Freda Cordy died on the 1st November 2015. An investigation was opened on 11th November and was concluded by way of an inquest on 13th April 2016. The medical cause of death was: 1a) Subdural haematoma b) Head injury 2 Hypertension, Ischaemic heart disease, dementia. A conclusion of accidental death was returned.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Cordy was a 93 year old frail lady with multiple diagnoses including dementia. On the 5th August 2015 Mrs Cordy was admitted to the Emergency Assessment Unit at Northampton General Hospital following a fall at her home address. Mrs Cordy had a history of previous falls. The medical team identified a need for constant supervision. A multiple disciplinary meeting including Social Services and the health partnership team decided that Mrs Cordy should be placed into Templemore Care Home. On 1st October 2015 Mrs Cordy was admitted to the care home, requiring full support for all personal care tasks. Despite the need for constant supervision that had been identified, the care home was only able to offer 2 hourly checks. No specific falls risk assessment was undertaken. Mrs Cordy fell from her bed at the care home on 2nd October 2015 suffering an extensive subdural haematoma. After a short stay in hospital, Mrs Cordy returned to Templemore Care Home on 7th October 2015 at which time a falls risk assessment was undertaken resulting in a mattress being placed beside her bed. On 15th October 2015 Mrs Cordy suffered a further fall from her bed at the care home suffering bleeding from her head. Mrs Cordy was then readmitted to Northampton General Hospital where she passed away at 7.13am on 1st November 2015 as a result of the injuries sustained in the falls.
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 could 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) Despite the medical team identifying a need for constant supervision, the multi disciplinary team placed Mrs Cordy in Templemore Care Home which was only able to provide 2 hourly checks. 2) Despite the previous history of falls and admission to hospital on 5th August 2015 being precisely due to a fall, no specific falls risk assessment was undertaken either before or upon Mrs Cordy's placement in the care home. 3) Although the provision of equipment was considered on 7th October 2015, this resulted only in the placing of a mattress on the floor and no other preventative equipment was considered.
6	**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 12th July 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] **Northampton General Hospital NHS Foundation Trust** [redacted] [redacted] [redacted] Similarly, you are 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.
9	**[DATE]** **17th May 2016** **[SIGNED BY CORONER]**