REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Ideal Care Homes Ltd**
1	**CORONER** I am Miss Stephanie Haskey, Assistant Coroner, for the Coroner area of Nottinghamshire
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 21st March 2016 an investigation was begun into the death of Olive Wilmott, who died on 30th December 2015. The investigation concluded at the end of the Inquest on 20th June 2016. The conclusion of the Inquest was that Olive Wilmott died as a result of the effects of a urine infection and severe Dementia, with a hip fracture which she suffered at Coppice Lodge Residential Care Home on 6th December 2015 being a contributory factor, and a Narrative Conclusion was recorded.
4	**CIRCUMSTANCES OF THE DEATH** Miss Wilmott was found on the floor of a communal area of the Home, having fractured her hip. The exact cause of this event remains unknown.
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. That there were references in the medical records to Miss Wilmott possibly having been pushed, but no or no effective investigation of the circumstances was made at the time and no Safeguarding referral was made. 2. That Miss Wilmott was assessed as requiring observation at 15 minute intervals, but there was no evidence that this had been in place and at the time of the event there were insufficient staff in place for her and other residents' needs (one staff member dedicated per floor of the dementia unit during the night shift).
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 16 August 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: 1. [redacted] 2. 3. I have also sent it to: 1. The Care Quality Commission 2. Nottinghamshire County Council Adult Safeguarding 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	**21 June 2016** **Stephanie Haskey**