	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Lambton House Care Home, New Lambton Village, Fencehouses, Houghton-le-Spring, Co. Durham, DH4 6DE**
1	**CORONER** I am Andrew Tweddle Senior Coroner for the coroner area of County Durham and Darlington.
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 21.09.2016 my Assistant Coroner commenced an investigation into the death of Doris Clarkson, 94 years of age. The investigation concluded at the end of the inquest on 29.11.2016. The conclusion of the inquest was The Result of a Fall with a cause of death of 1a) Hospital Acquired Pneumonia, 1b) Decreased Mobility, 1c) Fall resulting in Acute On Chronic Subdural Haematoma and Multiple Rib Fractures and 2) Atrial Fibrillation, Dementia, Osteoporosis.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of falls in the care home. It had been assessed that there should be a pressure sensor fitted to her bed to alert staff if she were to get out of bed unsupervised during the night. This pressure sensor was removed when a new mattress was fitted to the bed. The new mattress and the pressure sensor were incompatible. The deceased was then made subject to regular 15 minute checks during the night. The deceased was found on the floor after an unsettled night by a carer at approximately 03.25 hours. She was unable to give an account of what had happened. She sustained injuries which subsequently led to her death.
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) With a background of a history of falls when the pressure sensor was removed from the bed consideration might have been given to the immediate use of a pressure sensor mat on the floor in substitution therefore which would give an alert to staff if the deceased were to stand on it upon leaving her bed. Such a pressure mat would not prevent a person from falling but would give an earlier alert to staff that a person was out of bed when that person might ordinarily have been expected to have been in bed and this could lead to a reduction of risk of fatalities in the future. Regular 15 minute checks were not an adequate alternantive.
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 24th January 2017. 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] and the Care Quality Commission. 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]** 29·XI·16 **[SIGNED BY CORONER]**