	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Sunrise Senior Living, Solihull Falls Team, Care Quality Commission**
1	**CORONER** I am Emma Brown Area Coroner for **Birmingham and Solihull**
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 25/05/2016 I commenced an investigation into the death of Roger Harold Tombs. The investigation concluded at the end of an inquest on 9th February 2017. The conclusion of the inquest was: "Mr Tombs died as a result of an accidental fall. His needs had not been adequately re-assessed following a deterioration in his condition, which contributed to his death." In addition the jury made findings on the central issues of the case which were; 1. Was there any error or omission in the level of care provided to Mr Tombs that caused or contributed to his death? YES 2.Was there any error or omission in the sensor mat system that caused or contributed? NO.
4	**CIRCUMSTANCES OF THE DEATH** On the 4th May 2016 at 03:30, Roger Harold Tombs died at Queen Elizabeth Hospital, after admission following a fall at Sunrise Care Home in Knowle on the 3rd May 2016. Roger was subject to a Deprivation of Liberty Safeguarding Order, due to his learning disabilities. He was at high risk of falls and had had an increase in falls leading up to his death. Following a post mortem, the medical cause of death was determined to be: 1a BRONCHOPNEUMONIA 1b SEVERE TRAUMATIC BRAIN INJURY 2 DEMENTIA (DIFFUSE LEWY BODY TYPE)
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 evidence was that fall sensor mats had been placed either side of Mr. Tombs' bed on top of crash mats. At the time of his fall on the 3rd May 2016 the sensor mats did not sound an alert 2. The instructions for use of the sensor mats state they should be placed on a hard floor. 3. The investigating police officer from the public protection unit gave evidence that she was concerned that the crash mats below the sensor mats would reduce the effectiveness of the sensor mats and this could possibly be the reason the mat didn't sound (there were other possible explanations). 4. The evidence was that Sunrise of Knowle is still placing sensor mats on top of crash mats. 5. No expert opinion has been sought on this practice but the evidence of the investigating police officer was that the managing director of the local distributors of the mats told her this was an

	unsafe practice in his view. 6. It is my opinion that there is a risk that the effectiveness of the sensor mats is being reduced by placing them on crash mats and if this is the case they may not sound when vulnerable residents are mobilising exposing them to a risk of falls, injury and potentially death.
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 Monday 10th April 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: the family of Mr. Tombs and West Midlands Police. 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	13/02/2017 Signature_____ Emma Brown Area Coroner **Birmingham and Solihull**