

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Bondcare Limited
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 07/10/2016 commenced an investigation into the death of Frederick Bevan. The investigation concluded at the end of an inquest on 1st March 2017. The conclusion of the inquest was Accidental Death.
4	CIRCUMSTANCES OF THE DEATH
	Mr Bevan passed away on 4/10/16 at Bromford Lane Care Centre, 28 Fairholme Lane, Washwood Heath, Birmingham as a result of a head injury following a fall at the home on 22/9/16. Mr Bevan had been a resident of the Home since June 2014 and was subject to a Deprivation of Liberty Safeguarding Order due to his dementia. His health had deteriorated in the summer of 2016 with a number of falls recorded by the Home. On 22/9/16 he suffered another fall which was witnessed by a staff member at the Home. Paramedics attended the Home promptly and Mr Bevan was admitted to Heartlands Hospital quickly. Following medical assessments it was concluded that no treatment or procedure would be beneficial to him. The decision was taken to return Mr Bevan to Bromford Lane to ensure his remaining days were as comfortable as possible. He passed away shortly afterwards at the Home.
	Based on information from the Deceased's treating clinicians the medical cause of death was determined to be:
	1(a) SUBARACHNOID HAEMORRHAGE 1(b) FALL
	1(c) DEMENTIA 2 HYPERTENSION
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. —
	I was satisfied that Mr. Bevan's fall was witnessed by a carer. However, two paramedics who attended in response to the 999 call following the fall both gained the clear understanding that the fall was not witnessed, they described that there were 4 or 5 members of staff present and the scene appears to have been somewhat chaotic. The likely explanation for the paramedics misunderstanding is that a clear hand-over of the history of the incident was not provided by the witness, but rather the nurses who has responded to the emergency call 'took over'. This was accepted as a potential explanation by the home manager Judy Williams, who informed me that the policy is that the lead nurse should give the incident history to the paramedics: my concern is that if the history is not provided by the witness (regardless of whether they are a carer or a nurse) there is a risk that the correct history will not be given to emergency services which in some cases could have a detrimental effect on treatment.

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 Thursday, 4 th May 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: Mrs. 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	09/03/2017 Signature
	Emma Brown Area Coroner Birmingham and Solihull