for Bedfordshire and Luton

# REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

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| | **THIS REPORT IS BEING SENT TO:**<br>**The Manager**<br>**Abbotsbury Elderly Persons Home**<br>**Mead End**<br>**Biggleswade**<br>**Bedfordshire SG18 8JU** |
| 1 | **CORONER**<br><br>I am IAN PEARS, Acting Senior Coroner, for the Coroner area of Bedfordshire & Luton |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 3rd May 2017 I commenced an Investigation into the death of **BERYL MARGARET ELIZABETH GOODE** aged 84. The Investigation concluded at the end of the inquest on 22nd August 2017. The conclusion of the inquest was 'ACCIDENTAL DEATH'. The medical cause of death was:<br>I (a) Intracerebral Haemorrhage<br>1 (b) Fall<br>1 (c)<br>II Hypertension & Dementia |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the night of the 30th April 2017 the deceased fell whilst trying to use the commode. She denied any injury; was checked and put on appropriate observations. At around 01.00 hours she was found very confused in the corridor having visited another resident's room. The staff put this down to a urinary tract infection and did not consider the possibility of a head injury. She was then found on the floor of the corridor at 03.25 hours. As a result of the |

Senior Coroner, The Court House, Woburn Street, AMPTHILL, Bedfordshire, MK45 2HX
Tel 0300-300-6559 | Fax 0300-300-8267

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| | obvious head injury, the emergency services were called and she was taken to Bedford Hospital where she died on 2nd May 2017. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows :<br><br>(1) At no point did the night shift staff consider that a head injury could have been the cause of the deceased's confusion.<br>(2) It is accepted that the night shift are not medically trained. However, that makes it all the more important that they are aware of the possibility of a head injury to the residents, even in circumstances where the resident denies an injury.<br>(3) It is also accepted that the deceased may not actually have had a head injury from the first fall. Nevertheless, without training, the staff were not able to exclude a head injury.<br>(4) It is also accepted that calling the emergency services some 2 hours earlier would not have prevented her death if she had sustained a head injury in the first fall. However, in certain scenarios, residents in the future may have their lives saved if head injury is considered as a possible diagnosis. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe **Abbotsbury Elderly Persons Home** have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this Report within 56 days of the date of this Report, namely by **24th October 2017**. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] (the deceased's son-in-law). I have also sent it to **the Care Quality Commission** who may find it useful or of interest. |

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| | I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | Dated 29th August 2017<br><br>.....<br><br>**IAN PEARS**<br>**Acting Senior Coroner**<br>**for the Coroner Area of Bedfordshire & Luton** |

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