REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Registered Manager, Hillbrook Grange Residential Care Home, Ack Lane East, Bramhall, Cheshire SK7 2BY
1	**CORONER** I am Chris Morris, Area Coroner, for the coroner area of South Manchester
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 http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 25th April 2017, Alison Mutch OBE, Senior Coroner for Manchester South, opened an inquest into the death of Joseph Tarnowski who was aged 96 when he died at Stepping Hill Hospital, Stockport on 10th April 2017. The investigation concluded at the end of the inquest which I heard on 4th August 2017. The conclusion of the inquest was that Mr Tarnowski died as a consequence of injuries sustained in a fall at Hillbrook Grange Residential Care home. At the end of the inquest, I recorded a conclusion of Accident. The medical cause of death was 1a) Bronchopneumonia and acute heart failure 1b) Immobility 1c) Fall, fractured humerus
4	**CIRCUMSTANCES OF THE DEATH** Mr Tarnowski essentially enjoyed good health in his younger days. As years progressed, he developed some serious and debilitating health problems including deteriorating eyesight with wet macular degeneration. He also experienced a number of falls whilst living in his own home and as such, family members encouraged him to move to a residential care setting. Following an initial period living at a home in Bolton, Mr Tarnowski moved to Hillbrook Grange in April 2016. Mr Tarnowski settled into the home well, and essentially appeared to be in good health, although he did develop a number of chest infections. Mr Tarnowski walked independently with the help of a walking aid, and remained wholly independent in respect of most activities of daily living. At all material times, Mr Tarnowski retained capacity to make decisions about the support and assistance he wished to accept or refuse at any given time. On 7th April 2017, Mr Tarnowski fell whilst getting changed in his bedroom. He was unable to get himself up, and called out to staff who came to assist him. Mr Tarnowski was taken to Stepping Hill Hospital, Stockport, by ambulance where a displaced fracture of the neck of the left humerus was diagnosed. Mr Tarnowski was treated conservatively for this injury and admitted to hospital. On 9th April, Mr Tarnowski's condition deteriorated dramatically, and he sadly died the following day.

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. – In evidence at the inquest, it was confirmed that Mr Tarnoswki summoned assistance by shouting out to staff rather than by using his call-bell. It became apparent during the course of the hearing that Mr Tarnowski may not have been aware that his call-bell was wireless, and as such could be moved around his room. Additionally, the evidence revealed that even had Mr Tarnowski been aware that his call-bell was portable, he may not have been able to move it due to his reliance on a mobility aid. At the time of the inquest, consideration had not been given to introducing call bells which are worn by residents of the fashion that are apparently in use in some other similar residential care setting.
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 19th October 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 namely; 1) [redacted] sister of the deceased; 2) [redacted] (Partner, Weightmans LLP, Solicitors to North West Ambulance Service NHS Foundation Trust) I have also sent it to the Care Quality Commission who may find it useful or of interest. 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	**24/08/2017** **Christopher Morris** **Area Coroner** **Manchester South**