REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Advinia Healthcare Limited re: Cloisters Nursing Home, and 2. The London Borough of Hounslow
1	**CORONER** I am Gemma Brannigan, Assistant Coroner for West London
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** The inquest into the death of Mrs Pamela Craigie was heard with a jury on 14 September 2017.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Craigie was admitted to Cloister's Nursing Home, owned and managed by Advinia Healthcare Ltd on 21 December 2016. She had dementia and was mobile with the aid of a frame with wheels. She had fallen before, in hospital. The written plan at the Home was for a member of staff to be in the 'communal area' at all time. In the Home, she had a four falls: 1. On 18 January 2017 she fell in her room. An alarm sensor mat was then placed next to her bed. 2. On 31 January 2017 she fell in the lounge. This was witnessed by a staff member. Mrs Craigie had been sitting in a chair, she suddenly stood up, lost her balance and fell, hurting her face. She would not always remember to ask for help when she got up to mobilise, due to her dementia. 3. On 11 February 2017 she had her third fall in the Home. This time it was not witnessed by a member of staff, as staff were taking other residents to and from the dining room. Mrs Craigie had been sitting in a chair in the lounge, she was found on the floor and had hurt her forehead. After this fall, she was referred to the GP for physiotherapy. On 22 February 2017, a physiotherapist advised that Mrs Craigie needed 'constant instruction' to walk with a frame, and that she should have a sensor mat for her chair. The Home telephoned to order a sensor mat on 23 February. 4. On 24 February Mrs Craigie fell again in the lounge, where she had been sitting in a chair. This fall was not witnessed by staff, who were again taking residents to and from the dining room. Mrs Craigie was taken by ambulance to hospital where an acute subdural haematoma was diagnosed. Mrs Craigie remained bed-bound, and was returned to the Home for

	palliative care. Mrs Craigie died as a result of her head injury on 19 March 2017 at Cloisters Nursing Home, 70 Bath Road, Hounslow, TW3 3EQ. The jury returned the following in relation to the time, place and circumstances of the death: Pamela Craigie was admitted to Cloisters Care Home on 21st December 2016. She was subsequently deprived of her liberty for one year on 28th December 2016. Mrs Craigie died on 19 March 2017 at Cloisters Care Home as a result of a head injury sustained from a fall at the same location on 24 February 2017.Measures outlined in Mrs Craigie's care-plan completed on her admission were not consistently adhered to. On the day of her fall on 24 February 2017 specifically, Mrs Craigie was not always supervised in the communal area. And their conclusion was: Accidental. The Home had decided that Mrs Craigie did not need 1:1 care (or constant supervision), and she was not assessed or referred for funding for this. Before her death, there would not always be a member of staff in the lounge, especially at meal times. I was reassured to hear evidence from the Home that now: 1. there is always a member of staff in the lounge, even at meal times, and 2. there are sensor mats available to use on chairs.
5	**CORONER'S CONCERNS** However, I was concerned to hear evidence of the following: In relation to Advinia Healthcare Ltd 1. A resident would only be likely to warrant funding for 1:1 care if they were falling "almost every day, or every week". There is no set number of times they would be required to fall. However, it is not clear from the staff who gave evidence, when a referral for funding for 1:1 care should be made to the local authority, and based on what criteria. The Home should ensure that the criteria for 1:1 care is clear to staff. 2. That it is 'very difficult' to get funding from the local authority for 1:1 care. I am concerned that applications to the local authority for urgent 1:1 care are not being made, because the Home feel that they have been refused before and that a future application will not be successful. The Home should ensure that where the criteria for 1:1 care is met, that a referral for funding is always made. In relation to London Borough of Hounslow 3. If the Home does consider that a resident needs urgent 1:1 care e.g. because of a very high risk of falls, the Home sends a referral form to the London Borough of Hounslow. In their experience it takes two, or two-and a half weeks, for the urgent multi-disciplinary team (MDT) meeting to occur. This seems to be a very long time for an urgent assessment. In relation to Advinia Healthcare Ltd 4. Following the above, in the interim, the Home informs the family that the resident is a high risk of falls, but it is not clear how the high risk is managed effectively until 1:1 care is put in place (or until the MDT meeting). The Home should ensure that steps are taken to ensure the safety of the resident in the interim. I note that the London Borough of Hounslow (LBH) was not an interested person to the inquest. Mention of LBH arose only after the jury had retired to make their determination.

6	**ACTION SHOULD BE TAKEN** I feel that action should be taken in relation to the above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by. 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 Person: 1. The family of Mrs Craigie 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	**27 September 2017**