	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Care Quality Commission and Care First Class UK Ltd**
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 19/04/2017, I commenced an investigation into the death of James Albert Harris. The investigation concluded at the end of an inquest on 21st July 2017. The conclusion of the inquest was that death was as a result of natural causes contributed to by a fall and inadequacies in care before transfer to hospital.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased died in the Queen Elizabeth Hospital on the 3rd April 2017. He had been admitted to hospital on the 27th January as a result of sustaining a fracture in a fall at his home during the evening before. Surgery to fix the fracture was carried out successfully but Mr. Harris continued to deteriorate due to his underlying health conditions. It is likely that the fall was as a result of his general frailty but he ought to have received medical attention and been conveyed to hospital at that time. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a) PNEUMONIA 1b) CLOSTRIDIUM DIFFICILE INFECTION 2 FRACTURED NECK OF FEMUR (OPERATED), HEART FAILURE, ACUTE KIDNEY INJURY
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. – Mr Harris had been a resident at Cherry Lodge Care Home, 6 Manningford Road, Birmingham for 3 weeks prior to his fall on the 26th January 2017. The evidence gave rise to several areas of concern: 1. At the time of his fall one of his carers, [redacted] had not read his care plan or risk assessments. 2. His care plan stipulated that he was at medium risk of falls and should be accompanied when mobilising yet he mobilised to the bathroom from the lounge without assistance because the only member of staff present in the lounge was assigned to a resident requiring one to one observation and therefore could not accompany Mr. Harris. 3. Having fallen Mr. Harris complained of pain in his groin. The home's 'Protocol for all Falls' included that If the resident complains of pain in any part of the body following a fall they ought not to be moved and medical attention should be sought. Medical attention was not sought and Mr. Harris was returned to his room. The three carers who gave evidence at the inquest [redacted] and [redacted] all gave evidence that they had not seen the document entitled 'Protocol for all Falls' prior to Mr. Harris' fall on the 26th January 2017,

	although [redacted] and [redacted] were not found to be credible witnesses, [redacted] was credible. Evidence of police investigations identified that the Protocol ought to have been clearly available for staff around the home as a result of issues raised by the CQC prior to this incident. 4. Mr. Harris was not offered any analgesia despite his reports of pain. 5. Records of routine checks on residents are not made. Therefore whilst it was asserted that Mr. Harris was checked hourly throughout following the fall there is no evidence that the checks were carried out, by whom and what was found. 6. The home is currently without a registered manager and has been for sometime. All of the above contribute to a concern that staff at Cherry Lodge are not being sufficiently educated of falls policy and assessed on their awareness and application of policies, and also that there is inadequate record keeping.
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 18th September 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: Mr. David Harris. I have also sent it to [redacted] of West Midlands Police 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	21/07/2017 Signature_____ Emma Brown Area Coroner **Birmingham and Solihull**