REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Manager and Owners, "Bloomcare", Arden Court Nursing Home, 76 Half Edge Lane, Eccles, Salford.
1	**CORONER** I am Timothy W Brennand, HM Assistant Coroner for the Coroner Area of Manchester West.
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 the 19th day of June 2017 I commenced an investigation into the death of Kathleen Joan Devine, aged 94. The investigation concluded at the end of the inquest on the 8th November 2017. The medical cause of death was determined to be:- Ia Acute Left Ventricular Failure Ib Hypertensive Heart Disease II Surgery for Fractured Neck of Right Femur caused by a Fall Advanced Dementia There was a narrative conclusion that Kathleen Joan Devine died as a consequence of a combination of naturally occurring disease and injuries sustained in an accidental fall exacerbated by recognised complications of necessary surgical intervention and post-operative recovery.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of advanced dementia, osteoporosis, osteoarthritis and previous falls by reason of her aged related compromised mobility and was a resident at the Arden Court Nursing Home, 76 Half Edge Lane, Eccles. On the 8th June 2017 the deceased suffered an un-witnessed fall in her room whilst attempting to mobilise unsupervised in circumstances that remain unclear. A safety mat and sensor in the room had been unplugged and moved but it cannot be established that this had any bearing on the outcome. The deceased experienced increasing pain through the day and was subsequently transferred to the Salford Royal Hospital, Eccles Old Road, Salford where she was diagnosed with a fracture to her right femur. On the 9th June 2017, the deceased underwent a corrective right hemiarthroplasty conducted without event. Post

	operatively, the deceased's condition deteriorated by reason of the effects of surgery and her frailties and despite active treatment on the 10th June 2017 she became unresponsive and died at 4.44am that 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: The deceased sustained serious injuries as a result of an un-witnessed accidental fall in her room whilst attempting an unsupervised and unassisted mobilisation. The deceased had been correctly assessed as presenting as a high falls risk and required the deployment of a falls mat and sensor in her room at the Nursing Home. The mat and sensor had been unplugged and moved from the correct placement whilst the deceased was still in the room by herself. The last note of recorded care, intervention or observation was made at 6.30am on the 8th June 2017 stating that the deceased was asleep. The accident occurred at about 8.30am. By reference to the routine, after waking, the deceased would be placed on a chair near to her commode in the room. By inference, the fall took place as the deceased attempted to mobilise onto her commode. The evidence did not establish whether the deceased has mobilised from her bed or from her chair. The member of staff on duty at the time of the fall was an agency nurse who stated that there was no specific information on any handover sheet or care plan to the extent that she did not know who needed a mat or otherwise. Accordingly, the evidence established the following concerns:- 1. The failure of staff to record observations between 6.30am and 8.30am; 2. The removal and unplugging of a falls mat and sensor in the room of a resident with high risk falls who was awake, unsupervised and unobserved; 3. The quality and extent of handover instructions to agency staff;
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 17 January 2018. 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:-

	1. [redacted] (Son), [redacted] 2. Salford Adult Safeguarding Board, Salford City Council, 2nd Floor, Civic Centre, Swinton M27 5DA 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	**Dated** **22nd November 2017**	**Signed** **Timothy W Brennand,** **HM Assistant Coroner**