REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Managing Director Coxbench Hall Residential Home Alfreton Road Derby DE21 5BB
1	**CORONER** I am Anna Crawford, Assistant Coroner for the area of Derby and Derbyshire
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 April 2016 an inquest was opened into the death of Kenneth Cottam. The inquest concluded on 7 November 2017. The medical cause of death was recorded as: 1a.Acute Subdural Haematoma with Mass Effect. The inquest concluded with a narrative conclusion.
4	**CIRCUMSTANCES OF THE DEATH** Mr Cottam was an 89 year old gentleman and a resident at Coxbench Hall Residential Home. His mobility was limited and he used a zimmer frame and wheelchair at times. He had not had a fall since 2012 but was nervous about falling. From the morning of 4 April 2016 onwards staff recorded that Mr Cottam appeared confused. On 6 April 2016 he was observed to have a bruise on his right hip and stomach and he reported that on the night of 3/4 April 2016 he had fallen on to his bed. On 8 April 2016 Mr Cottam sustained an unwitnessed fall in his bedroom. He reported that he had lost his balance whilst standing up from his chair. He was checked over by a member of staff who did not observe any injuries and did not have any concerns. On 9 April 2016 a family member became concerned that Mr Cottam's speech was slurred and staff called an ambulance. Mr Cottam was taken to the Royal Derby Hospital where he was diagnosed with a subdural bleed with mass effect. He was managed conservatively. However, his condition deteriorated and he died at the hospital on 13 April 2016. Having heard evidence, the court was unable to establish whether Mr Cottam had sustained his head injury as a result of the reported fall on 3/4 April 2016 or the subsequent fall on 8 April 2016. The court heard evidence that a falls risk assessment was not carried out in relation to Mr Cottam, either on his arrival at Coxbench Hall Care Home on 1 March 2016, or after he reported having fallen on 3/4 April 2016. The court also heard that no consideration was given to a potential link between the confusion that Mr Cottam had been experiencing since 4 April 2016 and the fall that he

	reported sustaining on the night of 3/4 April 2016. As a result, the GP, who saw Mr Cottam on 8 April 2016 in relation to his ongoing confusion, was not informed about the reported fall or bruising.
5	**CORONER'S CONCERNS** Having heard evidence from the management team at Coxbench Hall Care Home, the court was not reassured that there are clear and robust policies and procedures in place in relation to falls prevention and falls management, or that those policies and procedures are widely and consistently understood by staff. The **MATTERS OF CONCERN** are as follows. – (1) The court was not reassured that there are clear and robust policies and procedures in place in relation to falls risk assessment and management. (2) The court was not reassured that staff had a sufficient understanding of the falls policies and procedures in place to enable them implement them consistently and appropriately.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date. I, the Coroner, may extend the period on request. 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: 1. [redacted] 2. Care Quality Commission 3. The Chief Coroner 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	**ANNA CRAWFORD** **7 DECEMBER 2017**