REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Manager of Fairfield View Care Centre, The Chief Executive of Tameside Metropolitan Borough Council**
1	CORONER I am Alison Mutch , Senior 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
3	INVESTIGATION and INQUEST On 27TH January 2017 I commenced an investigation into the death of Ivy Mitchell. The investigation concluded on the 11th July 2017 and the conclusion was one of Narrative: Died as a result of natural causes with a contribution being made by injuries sustained in an accidental fall. The medical cause of death was 1a Left sided bronchopneumonia; II Left subcapital fracture
4	Circumstances of the Death Ivy Mitchell was a resident at a care home. She had a history of falls. On 29th December 2016 she had a fall in her room. She appeared to mobilise afterwards. On the evening of 29th December she said she felt unwell. On 30th December following a discussion with her GP, a taxi was called and she went to Tameside General Hospital. A subcapital fracture and pneumonia was diagnosed. She was initially too unwell for surgery. She was operated on, on 7th January 2017. She dislocated her hip on 19th January 2017 but was not suitable for further surgery. She began to show further signs of infection on 25th January 2017. She deteriorated and died on 26th January 2017.
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. – 1. The documentation relating to the falls risk was inaccurate. It did not refer to previous falls and did not reflect her mobility; 2. There was a lack of understanding amongst the care home staff of risk assessments; reviews and the required process following a fall. This included documenting observations after a fall. 3. Processes relating to escalation following a fall were not complied with; and 4. There was a lack of understanding of the trigger for a referral to the community nutrition team.
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 12th 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, CQC and to the following Interested Persons namely [redacted] daughter of the deceased, 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	Alison Mutch O.B.E HM Senior Coroner 18th July 2017