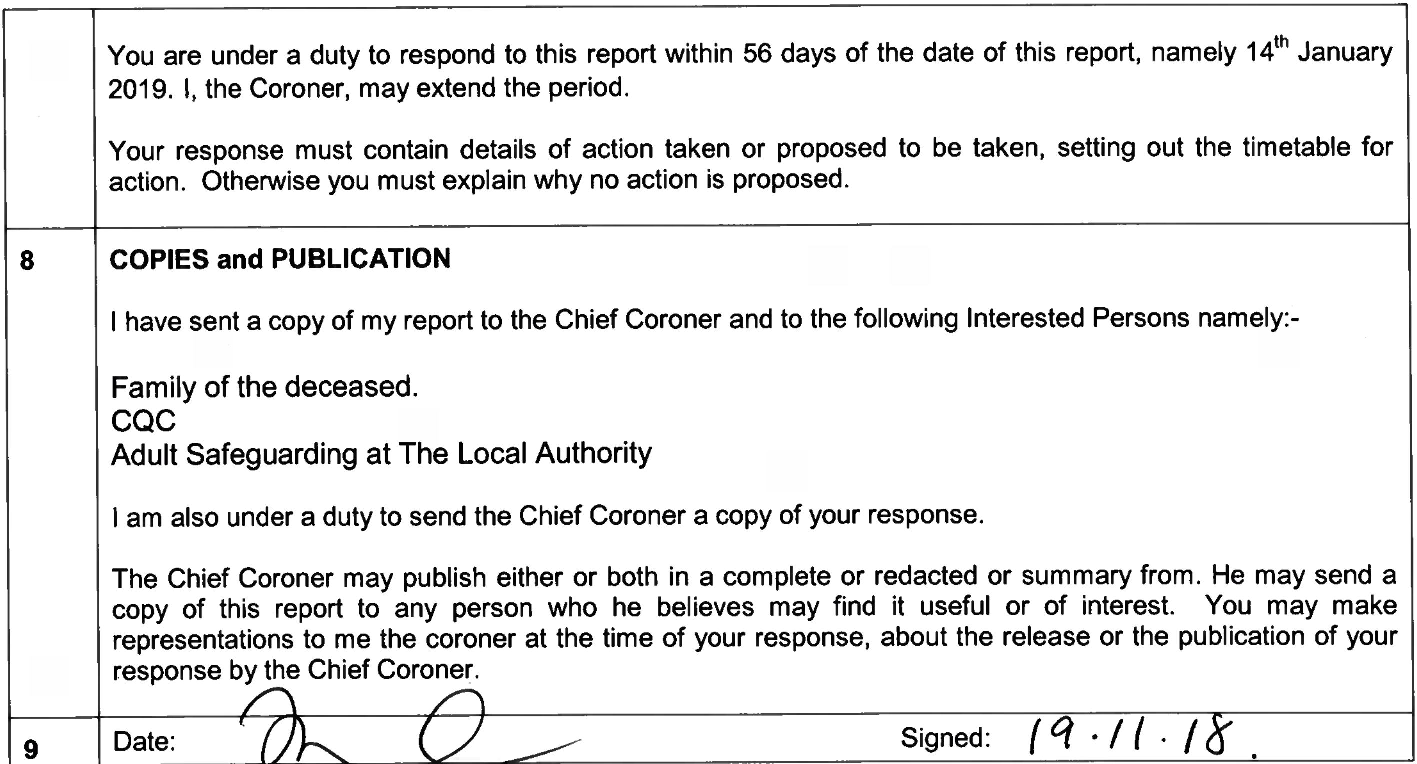
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. CEO of Beechwood Lodge Care Home, Meadow View, Norden, Rochdale
1	**CORONER** I am Ms J Robertson, Assistant Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 11 June 2018 I commenced an investigation into the death of **Beryl Ann Walsh**. I concluded this inquest on 8 November 2018 and found that there were multiple missed opportunities by Beechwood Lodge Care Home to refer the deceased to the falls team, undertake appropriate risk assessments and to provide her with falls prevention equipment.
4	**CIRCUMSTANCES OF DEATH** The deceased sustained catastrophic head injuries caused by an unwitnessed fall from her bed at Beechwood Lodge Care Home on 3 June 2018. This final fall led directly to the deceased's death.
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. That there were multiple missed opportunities to identify the deceased as a person of high risk of falls and to escalate her care by way of a referral to the falls team. Furthermore, there were multiple missed opportunities to provide the deceased with falls prevention equipment and to undertake falls risk assessments and care plans. I remain concerned that appropriate action to minimise the risk of deaths occurring in similar circumstances has not been taken by Beechwood Lodge Care Home. During the last 12 months of her life she had fallen on multiple occasions. However, she had not been referred to the falls prevention team and had not been provided with any falls prevention equipment. No care plans and falls risk assessments had been undertaken
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 14th January 2019. 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 namely:- Family of the deceased. CQC Adult Safeguarding at The Local Authority 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 from. 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	Date: Signed: 19.11.18.