REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Owner of Milford House Care Home, Derby Rd, Belper DE56 0QW **2.** Dr Chris Clayton, Chief Executive Officer, NHS Southern Derbyshire CCG, Cardinal Square, 1st Floor, North Point ,10 Nottingham Road, Derby DE1 3QT **3.** [redacted] Strategic Director, Adult Care at Derbyshire County Council
1	**CORONER** I am RACHEL SYED, Assistant Coroner, for the Coroner area of DERBY & 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 17 December 2013, an investigation was opened into the death of CHARLES EVAN GRAINGER which was concluded on Wednesday 09 May 2018. The conclusion of the inquest was Accidental death and the medical cause of death was accepted as being 1a. Bronchopneumonia, 1b.Central Cord Syndrome. During proceedings, the Court heard Pathology evidence which confirmed that Mr Grainger had essentially died from complications of Central Cord Syndrome following injuries sustained after a witnessed fall which occurred at Milford House Care Home on 24 November 2013.
4	**CIRCUMSTANCES OF THE DEATH** 1. The Court heard evidence that Mr Grainger was admitted to Milford House Residential Unit on 20 September 2013, following a fall which occurred at his home, resulting in a fracture to his right scapula and hospital admission at The Royal Derby Hospital. Following hospital treatment, he was discharged to Milford House for mobility rehabilitation which took place in conjunction with the Community Care Support Team/Occupational Therapy Team. Whilst Mr Grainger was known to have a long established history of falls which his Social Worker, [redacted] confirmed during her oral evidence, she stated that she was never required to share this important information with Milford House at the time they undertook his Pre-Assessment Admission, as his placement was funded by Health (now known as CCG), rather than the Local Authority. When challenged as to whether the system or process could be wrong she replied "*maybe*". 2. Following Mr Grainger's witnessed fall on 24 November 2013, [redacted] was also tasked to undertake initial investigations into the circumstances that led up to Mr Grainger's fall at Milford House. During evidence, [redacted] stated that she did not feel it necessary to request, review or retain Mr Grainger's falls risk assessment documentation to satisfy herself that he had received the necessary care. She made a number of assumptions and her enquiries lacked basic details which should have included requesting and reviewing the falls risk assessment. Her enquiries were slipshod and did not withstand basic scrutiny when

	investigating concerns of this nature.
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 could 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) Relevant information regarding Mr Grainger's falls history could not be shared by his Social Worker with other relevant Multi Agencies such as Milford House or the Health Team at the time his Pre Admission Assessment was undertaken as the process/system did not allow it. Milford House, the Local Authority and the Health Team should have all worked together, more cohesively to ensure they were working in Mr Grainger's best interests. Failure of Multi Agencies to work more cohesively in the future by sharing a patients past medical history, including previous falls history could result in vital information being missed and future deaths occurring. (2) [redacted] did not consider it important or necessary to request, review or retain copies of Mr Grainger's falls risk assessment as part of her basic investigation enquiries. Failure to undertake a basic and proper investigation could result in future deaths occurring.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 **11 July 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 [redacted] **(Bereaved Family)** 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	**12 May 2018** Rachel Syed **Rachel Syed, Assistant Coroner for Derby and Derbyshire**