	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Directors of Cole Valley Care Limited [redacted]
1	**CORONER** I am Mr James Bennett HM Assistant Coroner for Birmingham and Solihull.
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 26/11/2018 I commenced an investigation into the death of Jean Mary Cutler. The investigation concluded at the end of an inquest on 25/01/19. The conclusion of the inquest was that the Deceased died from a combination of natural causes, namely osteoporosis and an accidental fall.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased had severe dementia and was bed and chair bound with no independent mobility. She was prone to falling. At her care home in July 2018 she fell out of bed, and required surgical repair of a fractured left femur, when she was also diagnosed with osteoporosis. It was therefore recommended she reside at a nursing home given her increased care needs and the high risk of falling, and she was accepted at Cole Valley Nursing Home in August 2018. On arrival she was assessed as being at high risk of falling. The risk of falling from a wheelchair was recognised. When outside the home residents were to have a lap belt, but not inside, and therefore she was not to be left unattended. The nursing home was understaffed. On 5/10/18 one member of staff was present in the communal dining area but was unable to prevent the Deceased from falling out of her wheelchair. Having developed swelling, on 14/10/18 she had an x-ray at hospital which revealed the fall had caused a fractured left femur, which was treated conservatively. She died on 18/10/18 at the nursing home. The medical cause of death was determined to be: 1a. LEFT PERIPROSTHETIC NECK OF FEMUR FRACTURE 1b. OSTEOPOROSIS 2. ADVANCED VASCULAR DEMENTIA
5	**<u>CORONER'S CONCERNS</u>** 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. Cole Valley Nursing Home is run a by a private company and cares for up to 45 residents who are vulnerable due to their age and physical and mental health issues. 2. Pre-incident, the risk of residents falling from a wheelchair was recognised. There was an inconsistent approach to managing this risk; Outside the nursing home a lap belt would be attached to the wheelchair. Whereas inside the nursing home no lap belt was used. A member of staff was expected to be able to intervene when a resident was in the process of falling. 3. I heard evidence that following the incident the Care Quality Commission and Clinical Commission Group had requested from the nursing home copies of revised risk management documents. In my opinion this has led to the nursing home being given the impression their management of residents from falling out of wheelchairs is adequate. 4. However, the inconsistency of using lap belts outside the nursing home, but no similar restraint device when inside remains. The reliance on a member of staff being able to intervene in time continues despite the incident on 5/10/18 revealing the inadequacy of this as a safety measure. The nursing home has not investigated the availability and use of restraint devices inside the

	nursing home. My on-going concern is that there remains a risk of vulnerable residents falling out of wheelchairs. 5. The nursing home's internal investigation recognised as root causes of the incident a lack of internal knowledge and guidance, that the home has been through a hard time recently and it had impacted on the staff, that care plans did not give correct guidance to staff, and that management was unstable. However, the only post-action event listed was an 'incident debrief'. The nursing home manager agreed when giving evidence that the action plan would have been more effective if it had included a review of the falls risk assessment, the viability of restraint devices being used both outside and inside, and a review of whether staff numbers were adequate. My on-going concern is that the post incident investigation was inadequate and lessons have not been learned. 6. The current falls Risk Management and Risk Assessment documents (requested by the CQC and CCG) are undated and unsigned and continue to place reliance on the presence of a staff member to prevent falls. My on-going concern is that the falls risk assessment has not being adequately completed.
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 5 April 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. I have sent a copy of my report to Mary Cutler's husband Michael Cutler who was an Interested Person. I have sent a copy to the Care Quality Commission and Clinical Commission Group 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	08/02/2019 Signature  Mr James Bennett **HM Assistant Coroner** **Birmingham and Solihull**