REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Rosehill House Care Home, Keresford Road, Dodworth, Barnsley, S75 3EB**
1	**CORONER** Tanyka Rawden, Assistant Coroner for South Yorkshire (West)
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** On 6 September 2017 an investigation was commenced into the death of Ronald Houchin aged 84 years. The investigation concluded with an inquest on 20 November 2018. The inquest was assisted with evidence from the manager of Rosehill Care Home, [redacted] a social worker and a team manager from Barnsley Metropolitan Borough Council, and [redacted] consultant in the care of the elderly. The conclusion of the inquest was: Ronald Houchin died as a result of falling at Rosehill House Care Home. Care plans and falls risk assessments were not carried out or reviewed regularly and when they were carried out, the recommendations were not followed. Had Rosehill Houses' own recommendations been followed, Mr Houchin may not have fallen and sustained the head injury which caused his death.

CIRCUMSTANCES OF THE DEATH

Ronald Houchin began attending Rosehill House Care Home on 31.12.15 for day care and occasional respite care.

On 31.12.15 a falls risk assessment was carried out and records there was a medium risk of Mr Houchin falling and he should be assisted and supervised while walking.

On 10.05.16 Mr Houchin fell, unwitnessed, in the bathroom. No changes were made to is care plan and a further falls risk assessment was not carried out.

On 28.06.16 a further falls risk assessment was carried out and records there was a high risk of Mr Houchin falling. His care plan was not changed.

On 20.12.16 Mr Houchin fell, unwitnessed, outside. No changes were made to his care plan and a further falls risk assessment was not carried out.

On 18.05.17 Mr Houchin fell, unwitnessed, outside. No changes were made to his care plan and a further falls risk assessment was not carried out.

On 21.05.17 Mr Houchin fell, unwitnessed, outside. No changes were made to his care plan and a further falls risk assessment was not carried out.

On 27.05.17 Mr Houchin fell, unwitnessed, outside. No changes were made to his care plan and a further falls risk assessment was not carried out.

On 08.06.17 Mr Houchin fell, unwitnessed, in the lounge. No changes were made to his care plan and a further falls risk assessment was not carried out.

On 17.06.17 Mr Houchin fell, unwitnessed, outside. No changes were made to his care plan and a further falls risk assessment was not carried out

One 19.06.17 Mr Houchin fell twice, unwitnessed, once in the lounge and once in the toilet. No changes were made to his care plan and a further falls risk assessment was not carried out.

On 24.06.17 Mr Houchin fell six times, unwitnessed, once in the bathroom, twice outside and three times in the lounge. No changes were made to his care plan and a further falls risk assessment was not carried out.

On 26.06.17 a further falls risk assessment was carried out and records there was a high risk of Mr Houchin falling. No changes were made to his care plan.

On 19.07.17 Mr Houchin fell, unwitnessed, in the bathroom and was admitted to hospital. He was found to have bilateral subdural haematomas.

On 31.07.17 he was discharged to Rosehill House Care Home. No changes were made to his care plan and a further falls risk assessment was not carried out.

On 10.08.17 Mr Houchin fell, unwitnessed, outside. No changes were made to his care plan and a further falls risk assessment was not carried out.

On 01.09.17 Mr Houchin was admitted to hospital with shortness of breath and presented as "..unwell and sleepy..". A scan showed progression of the left sided haematoma.

Mr Houchin died on 05.09.17 at Barnsley General Hospital. The medical cause of death is:

1a. Aspiration pneumonia
1b. Subdural haematoma
II. Stroke, frailty, vascular dementia

5	**CORONER'S CONCERN** During the course of the investigation my inquiries 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 **MATTER OF CONCERN** is as follows. – Evidence was given before the Court that the falls risk assessment carried out on 31.12.15 was not followed. As such Mr Houchin was not assisted and supervised when mobilising. Mr Houchin fell seventeen times between 31.12.15 and 10.08.17. The falls risk assessment was updated twice between 31.12.15 and 10.08.17. Mr Houchin died as a result of aspiration pneumonia caused by a subdural haematoma sustained in an unwitnessed fall. In my opinion there is a risk that future deaths may occur unless a system is established within Rosehill House Care Home whereby falls risk assessments are conducted regularly and assessments and care plans are followed.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 23 January 2019. I may extend this period upon your application. 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] Others sent copies for information: 1. CQC via email 2. Barnsley District Council 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.

Mrs Tanyka Rawden

28 November 2018