REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Registered Manager of Reinbek Care Home
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 4th July 2018 I commenced an investigation into the death of Ruth Gregory. The investigation concluded on 7th January 2019 and the conclusion was one of **Narrative: Died from natural causes contributed to by the recognised complications of an accidental fall.** The medical cause of death was **1a) Aspiration Pneumonia; II) Infected Right Total Knee Replacement**
4	Ruth Gregory had significantly reduced mobility following a fall resulting in a total knee replacement. Subsequently she developed an infection in her knee and was treated at Stepping Hill Hospital. She returned to Reinbeck Care Home where she began vomiting - suggestive of an upper GI bleed. She was readmitted to Stepping Hill Hospital where she deteriorated due to aspiration pneumonia and died on 2nd July 2018.
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. – The inquest heard that Mrs Gregory's had required the knee replacement after being knocked over by another resident in the care home. The

	inquest was told that residents were regularly left unsupervised in communal areas of the care home and that this meant similar incidents could reoccur leading to trauma and consequential death. There was no detail available at the inquest about how this risk was managed and arrangements to ensure supervision of communal areas.
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 8th March 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 [redacted] Mrs Gregory's daughter, 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 OBE** **HM Senior Coroner** **11.01.2019**