REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Managing Director, Glebelands Care Team, Glebelands, 90, Love Lane, Mitcham. CR4 3DD.
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 the 13th November 2019, evidence was heard touching the death of **Barry Jack Gordon Liffen**. Mr Liffen had died at St George's Hospital on 11th May 2019, following injuries sustained in a fall at his sheltered accommodation. He was 85 years old. **Medical Cause of Death** I (a) Hospital Acquired Pneumonia (b) Subdural Haemorrhage II Hypertension, Atrial Fibrillation (anticoagulated) **How, when, where Mr Liffen came by his death:** Mr Liffen suffered with dementia and other chronic illnesses which caused him to be unsteady on mobilising. He was also taking anticoagulants for atrial fibrillation. On 10/3/2019, he fell in the night sustaining a head injury which caused subdural bleeding. This progressed until his condition deteriorated such that an ambulance was called on 22/3/2019. He was admitted to Croydon University Hospital then St George's Hospital. The bleed stabilised but he developed recurrent pneumonia which ultimately took his life on 11/5/2019 at St George's Hospital. **Conclusion of the Coroner as to the death:** Accidental fall on a background of chronic medical illnesses and anticoagulation.
4	Extensive evidence was taken in court. In summary, of relevance to this report: He lived at Glebelands in his own flat with 24 hr carers on site. By Oct/Nov 2018, his care needs increased such that he needed 3 visits a day, help with personal care and taking his medication. In 2019 he fell twice. The first time was 19th January 2019. He

	was admitted to hospital and had a CT head scan on 21/02/2019 which did not show any acute pathology. He fell again on 10/3/2019 during the night. He was seen by Glebelands staff on the floor and was unable to say how he had fallen. He got himself up and there were no overt injuries but neither clinical assessment nor advise was sought by the attending carers. He was initially well, but from 18th March 2019, he acutely deteriorated, such that by 22/3/2019 an ambulance was called. At this point he could not feed himself, communicate nor mobilise. He was admitted to hospital and found to have an intracranial bleed and his anticoagulation stopped. It is possible that had the head injury been diagnosed earlier, anticoagulation could have been reversed earlier and the injury been less severe, such that the death may have been avoided. None of the carers attending Mr Liffen were clinically trained.
5	**Concerns of the Coroner:** 1. That clinical assessment be sought for frail persons resident at Glebelands following falls. 2. That clinical assessment be sought for persons at Glebelands whose health is noted to have deteriorated by staff.
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. 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 :  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	**17th December 2019** **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Honorary Professor QMUL School of Medicine and Dentistry**