REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sunrise care home**
1	**CORONER** I am Louise Hunt, senior coroner, for the coroner area of 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 17/07/15 I commenced an investigation into the death of Allan Richard Beasley. The investigation concluded at the end of the inquest on 22/10/15. The conclusion of the inquest was: The deceased died from a traumatic cervical spine fracture following 7 falls. The initial risk assessment was inadequate. There was a failure to correctly document the falls as they occurred. The risk assessment was not updated and there was no referral to the falls team for further assessment. These failures contributed to his death..
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from vascular dementia. He was admitted to Sunrise care home on 21/05/15 as he could no longer manage at home. An initial moving and handling assessment confirmed that he could mobilise with 2 sticks but he needed supervision. He was noted to be unsteady on his feet at times. After admission he had a number of falls. 03/06/15 at 15.00 – the deceased was walking to the lounge with his son and lost his balance and fell with no injuries. 13/06/15 – the deceased had two falls. At 08.30 he was found on the bedroom floor shouting for help and he had grazed his right forearm. At 09.30 he was found on the floor with a skin tear to the right wrist. 17/06/15 at 12.00 – he was found on the floor in the corridor with no injuries. 22/06/15 – no incident form but the deceased was noted to have been found on the floor near his bed and had defecated on the carpet. 29/06/15 no time recorded – He was walking alongside another resident when there was some sort of altercation with that resident and the deceased fell and grazed his head and bruised his eye. The incident was reported to the police and no further action taken. On 04/07/15 he suffered a further unwitnessed fall in the dining area. He was admitted to Birmingham Heartlands Hospital the same day. A CT scan confirmed C1 burst cervical fracture and a fracture of the odontoid process named as a type 2 odontoid peg fracture. He was treated with a collar but due to his vascular dementia he kept removing the collar. He developed a chest infection. He continued to deteriorate and passed away on 09/07/15. An external review after the events confirmed the following: • The initial risk assessment did not indicate all the risk factors which may contribute to falls. • There is no evidence the initial documents were ever reviewed or that the deputy manager was aware of the number of falls. • Staff failed to follow the falls prevention policy and failed to correctly record

	incidents. • The monthly wellness check was not completed at the end of June 2015, and the monthly falls analysis log was not completed. • An uneven floor may have contributed to the fall.
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 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) Staff were unaware of the Home's Falls Prevention Policy. This meant staff failed to correctly record falls and escalate to appropriate senior staff. (2) The falls monthly log was not completed on a daily basis as it should have been. The log was not completed for June as staff were too busy. This resulted in trends being missed and staff being unaware of the frequency of Mr Beasley's falls. (3) 15 minute observation forms were found to be inaccurate as staff in the office were completing the form when not seeing the patient. In addition the observation forms were felt to be inaccurate as a member of staff signed for observations when it was found they were undertaking another task. (4) Documentation is not completed contemporaneously but at the end of the shift. (5) The home has a policy that the first fall of a resident is treated as an isolated incident and no further action is taken. (6) The home has a policy that they only escalate to the falls team if a resident has had 3 falls. (7) The falls tracker was not completed for Mr Beasley. (8) The falls incident forms were not correctly reviewed by senior staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 21 December 2015. 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, the family, Care Quality Commission and West Midlands Police. 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	**26th October 2015**