REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Victoria Weller, Managing Director of Your Health Ltd
1	**CORONER** I am Miss Stephanie Haskey, Assistant Coroner for the Coroner area of Nottinghamshire
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 8th April 2015 an Inquest into the death of Elsie Marjorie Brown was opened, and it was resumed on 30th November 2015, concluding on 4th December 2015.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Brown fell from her bed at Langwith Lodge Residential Care Home on 23rd March 2015 and suffered a fractured left humerus and right hip. She died on 5th April 2015 at Chesterfield Royal Hospital as a result of bronchopneumonia and lobar pneumonia, which developed as a result of these fractures.
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. There was no falls risk assessment nor bed rails assessment in place for Mrs Brown, nor was her mental capacity assessed. 2. Mrs Brown's care plan was incomplete, unsigned, undated and never reviewed, despite Mrs Brown falling from her bed on 8th March 2015. 3. No referral was made to the Falls Team nor (by Langwith Lodge) to Derbyshire Community Health as regards the question of bed rails. 4. There was a lack of clarity as to where the responsibility for an initial bed rails assessment lay. 5. There was an insufficiently robust auditing process, in that the omissions were not identified by Langwith Lodge nor by Your Health Ltd. 6. Mrs Brown's fall on 23rd March 2013 was not handed over, nor recorded nor reported, and there was a lack of clarity amongst staff as to where responsibilities for these matters rested. 7. A member of staff who had responsibility for record making could not effectively and independently do so due to poor literacy skills. 8. That the night time provision of two staff members to cover the main Lodge and two to cover the Horton Suite (two separate but joined buildings) was not seen as a minimum requirement to ensure the health and safety of residents when at least one resident in each building needed the assistance of two carers, but that

	only three were regularly rostered for the night shift. 9. Handovers were not regarded as integral to the staff's paid shift and were informal and unpaid.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 ..... 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: 1. Members of Mrs Brown's family 2. [redacted] for Your Health Ltd 3. [redacted] for [redacted] and Nurse Byrne 4. [redacted] for Bassetlaw Older Adults Social Care Team 5. [redacted] Solicitor for the Care Quality Commission 6. [redacted] of Nottinghamshire Police. [redacted] and [redacted] may have copies upon request. 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	**[DATE]** 14th December 2015 **[SIGNED BY CORONER]** **Stephanie Haskey**

Miss Stephanie Haskey
Assistant Coroner