MISS N PERSAUD
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email [redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU** 2. **Havering Clinical Commissioning Group, 6th floor, North House, St Edwards Way, Romford RM1 3AE**
1	**CORONER** I am Graeme Irvine, Area Coroner for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 7th July 2020 I opened an investigation touching the death of Ann Doris Stillwell, aged 78 years old. I opened an inquest on the 15th July 2020. The inquest concluded on the 3rd December 2020. The conclusion of the inquest was accidental death The medical cause of death was; 1a Pneumonia 1b Left Neck of Femur Fracture (operated) II Frailty, Asthenia

4	**CIRCUMSTANCES OF THE DEATH** On 22nd June 2020 Mrs Stillwell was discharged from hospital to a care home following the surgical repair of a broken right neck of femur sustained in a fall in a care home on 25th May 2020. Mrs Stillwell was at high risk of falls caused by a combination of factors; Mrs Stillwell's frailty, her dementia which limited her perception of risk, whilst at the same time made her forget her mobility restrictions and her independent and assertive nature. Discharge notes recommended a high level of supervision, noting a significant history of falls, dementia, and mobility issues. Following a pre-admission assessment, the care home manager asked the commissioner to authorise funding for 1:1 care, this was declined. On the morning of 3rd July 2020 Mrs Stillwell sustained a fall in her care home whilst subject to general observations. No apparent injury was found. The care home manager renewed her application to commissioner for funding for 1:1 care. On the afternoon of 3rd July Mrs Stillwell sustained another fall and this time suffered a left-sided neck of femur fracture. Despite medical treatment she succumbed to complications of her injuries and died on 5th July 2020.
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 could 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. Mrs Stillwell was at high risk of falls during the entirety of the period of 25th May 2020 until the 3rd July 2020. During that period the Commissioner for her care did not authorise 1:1 care. 1:1 care would have been the only way in which the particular risk presented by Mrs Stillwell to herself could have been mitigated.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 **29th January 2021**. 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 the family of Mrs Stillwell and the CQC. I have also sent it to the Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

	I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.	
9	**8th December 2020**	**[SIGNED BY CORONER]**