	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**,** **Proprietor,** **Riverside Rest Home** **17 West Beach,** **Lytham St Annes,** **Lancashire,** **FY8 5QH**
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
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** The death of Joan Elizabeth Rutter on 23rd October 2020 was reported to me and I opened an investigation, which concluded by way of an inquest held on 2nd March 2021. I determined that the medical cause of Joan's death was: 1 a Fracture of cervical vertebral column 1 b Fall 1 c 2 Chronic kidney disease, urinary tract infection and ischaemic bowel In box 3 of the Record of Inquest I recorded as follows: Joan Rutter was at high risk of suffering a fall. At shortly after 7 am on 23 October 2020, Joan was found by a member of the staff at the rest home where she resided and was unresponsive on the floor next to her bed. A Paramedic was called and he confirmed that Joan was deceased. Joan had suffered an unwitnessed fall to the floor between her bed and bedside table. Staff were unaware that Joan had sought to leave her bed. This was in part because at that time the falls mat positioned by the side of her bed in order to alert staff when she moved was unplugged. A subsequent post mortem examination revealed Joan had received a fracture to the spine as a result of the fall the effects of which proved fatal. At the time of her fall, Joan's physiological reserve was already weakened by her kidney disease, a urinary tract infection and a developing ischaemic bowel. The conclusion of the Coroner was that Joan Rutter died due to **Accidental death**
4	**CIRCUMSTANCES OF THE DEATH**

	Joan Rutter, aged 94 years, was at high risk of falling. Care staff were to check upon her every two hours. She had a falls mat positioned by the side of her bed. Staff were aware that her levels of confusion had worsened during the time she had resided at the rest home. There were personal alarms available to Joan, but the court head that Joan's confusion was such she would not have appreciated that these alarms were available for her to utlilise should she require assistance. Staff knew that Joan had a tendency to wander during the night. During the inquest, evidence was received that during the night two members of care staff had been responsible for checking on the welfare of up to approximately 24 residents. Staff were expected to check on Joan at 5am that morning. Having considered the available evidence, the court was unable to conclude that this 5am check did take place. It was shortly after 7 am when a third member of staff arrived to commence her shift, and when she entered Joan's room to check on her welfare, she found Joan unresponsive. The court found that there would have been periods overnight when Joan may have required the assistance of staff but that this may not have been available when she needed it and this placed her at risk. There would have been times when staff members were in other parts of the building checking on other residents, and they would have been unaware that Joan may have been seeking to leave her bed / bedroom. Staff would not have been alerted had Joan stepped onto the pressure mat by the side of her bed because as was revealed in court the mat was not plugged in at the relevant time and was therefore ineffective. From the available evidence, it could not be established how the mat came to be unplugged. Had it been operative when Joan left her bed, staff may have been alerted to her movements, but this would have been dependent upon the proximity of the two care staff and where they were in the building at that time? In the view of the court, at various times overnight those Carers would have been unaware Joan had moved from her bed or otherwise required assistance. When Joan did fall, the court heard that her death would have been instantaneous.
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 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. – <u>Record keeping.</u> The standard of the records provided by the rest home were poor. There was a paucity of entries made during the night shift. For example, entries to reflect Joan had been found wandering in the rest home having left her own room were unrecorded. A member of the day staff taking over the care of residents would have found it very difficult to review the records and have an accurate understanding of how the residents had presented overnight, thereby placing such day staff in a difficult position taking over the care of often elderly, vulnerable residents but potentially unaware of recent important events. Although the court received some evidence that changes have been made since Joan's death, the court remains of the view that the standard of record keeping continues to pose a risk to residents and future deaths may occur. <u>The delivery of care during the night shift.</u> Joan was an elderly, vulnerable resident. She was known to be confused, and unlikely to utilize personal alarms, and had a tendency to leave her room. She may have left her room at times

	when staff were not available to respond to her movement because they were elsewhere in the building. The court is concerned that the night shift operated in a way that meant that staff could be unaware residents needed their assistance. Again, although the court heard that some changes have been made, the court remained of the view that the way care is delivered overnight to residents such as Joan poses a risk to their welfare and future deaths may occur.
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 5th May 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: [redacted] – Daughter of Mrs. Joan Rutter The Care Quality Commission Head of the Quality, Contracts and Safeguarding Adults Service, Lancashire County Council 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	08/03/2021 Signature_  Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**