REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Rochcare 75-77 Drake Street, Rochdale OL16 1SB
1	**CORONER** I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 9th July 2020 I commenced an investigation into the death of **Mrs Amy Chiverall**
4	**CIRCUMSTANCES OF DEATH** Mrs Chiverall was a resident of Royley House Care Home, Lea View, Royton. On the 1st July 2020 she had an unwitnessed fall in her room. The Court heard evidence she was a moderate risk of falls. Her call bell (which are fixed items) was in her room but not within her reach. Her fall is likely to have occurred some 1-2 hours before she was found. Medical attention was not sought in a timely manner and post fall observations were not conducted in line with the Care home policy. When she was admitted to hospital on the evening of the 2nd July 2020 she was found to have multiple rib fractures and a traumatic pneumothorax. Mrs Chiverall died on the 3rd 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 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:- The Court heard the home do not use pendant call alarms. This was described as a business decision. The Home has 18 residents of mixed falls risk but less than half would be of a moderate or high risk of falls. The Court was concerned that for those residents a fixed call bell may not be of assistance, as in this case, as it would be out of reach when required.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 10/07/2021. 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 namely:- The family of Mrs Chiverall 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 from. He may send a copy of this report to any person who he believes may find it usefulor 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: 14.4.21. Signed: