REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Castlehill Specialist Care Centre** **2. CQC**
1	**CORONER** I am Mrs Joanne Lees, Area Coroner for the coroner area of The Black Country.
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 11/12/20 I commenced an investigation into the death of Eric Harold Bird. The investigation concluded at the end of the inquest on 9/2/21. The inquest found and recorded the following facts; **On the evening of 21/11/20 the deceased, a 91-year-old gentleman suffered a fall at the care home where he was residing. Mr Bird suffered with vascular dementia and was assessed as being at high risk of falls. He was independently mobile and had a history of recent falls resulting in bruising to his person and was taking apixaban. He suffered with hypertension, atrial fibrillation and frailty. On 21/11/20 he was seen by a member of staff to fall between two sofas and fall backwards from a standing position hitting his head on the ground as he fell. An ambulance was called, and he was taken to hospital later than evening where he was found to have sustained a subdural haematoma which was managed conservatively. He sadly passed away in hospital on 30/11/20.** The medical cause of death was established as; 1a) Subdural Haematoma 1b) Fall 2) Hypertension, Atrial Fibrillation, Dementia, Frailty **The Coroner's conclusion was one of Accident**
4	**CIRCUMSTANCES OF THE DEATH** On 20/10/20 the deceased, a 91-year-old gentleman suffering with Dementia was admitted to Castlehill specialist care centre. On admission, a falls risk assessment was undertaken where the deceased scored as being at high risk of falls. I heard in evidence that the care home put in place two measures to address this risk; 1) a member of staff to be present in communal areas at all times observing residents and 2) an acoustic monitoring alarm system in Mr Bird's bedroom. It was understood that a high/low bed was standard in the home. Mr Bird was described as being independently mobile and needed no additional walking aids. He was taking lorazepam which may have increased his level of agitation and thereby his risk of falls. He required 24 hour care for his own safety. The court heard in evidence that between Mr Bird's admission on 20/10/20 and 21/11/20 inclusive, he suffered seven falls in a 4-week period whilst a resident at Castlehill. Five of those falls were unwitnessed. Four of those falls took

	place whilst Mr Bird was in the bedroom and the fifth in a nursing station. Two falls were witnessed and took place in the communal areas of the unit where Mr Bird was placed. Three of the seven falls resulted in Mr Bird hitting his head. The latter fall on 21/11/20 resulted in a subdural haematoma which led directly to the death of Mr Bird. I also heard evidence that there had been a change of management at the home and that there had been a recent inspection by the CQC but I was unaware of the outcome.
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. After Mr Bird's admission and initial falls risk assessment, there was a reference that Mr Bird needed to be referred to the physio team but no evidence this was actually done; 2. The inquest heard that Castlehill polices had not been followed after each fall whereby Mr Bird had hit his head. Mr Bird was taking apixaban which meant he was at a higher risk of bleeding. Evidence was heard that policy required 999 to be called. This was not done on 1/11/20 nor on 14/11/20. 3. On 21/11/20 the nurse on duty called 111 instead of following policy to call 999; 4. On 21/11/20 I heard evidence that the fall occurred at approximately 20.20/20.30 hours. Records suggested the 111 service was contacted at 21.06. I heard evidence that it was the 111 service that made arrangements for an ambulance to attend and the EPR showed that the ambulance was contacted at 21.34 arriving on site at 21.47; 5. On arrival the ambulance was unable to gain access to the care home until 22.11 as there was no answer at the door. I heard evidence at the inquest that arrangements had now been made for a staff member to wait in the reception area when an ambulance is now called out of hours to facilitate entry; 6. There was no evidence that Mr Bird's falls risk assessment and falls care plan had been updated after every fall; 7. There was no evidence of any changes being made to Mr Birds falls care plan after the fall on 14/11/20 and no rationale recorded for not doing so; 8. I heard evidence that after the fall on 21/11/20 whereby Mr Bird was taken to hospital, that senior management who were off site were not contacted for over 2 hours after Mr Bird fell; 9. There were discrepancies in the recording of the falls on the monthly accidents and incidents form and no evidence that any consideration had been given to a pattern of falls which needed to be addressed to reduce Mr Bird's apparent increasing risks.
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 **(9/4/21)**, 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 [redacted]. 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	**10/2/21**  **Mrs Joanne M. Lees**