MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
East London Coroners Court, Queens Road, Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Care Home Manager, Cherry Orchard Nursing Home, 1 Richard Ryan Place, Dagenham, Essex, RM9 6LG [redacted]
1	**CORONER** I am Graeme Irvine, acting senior 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 18th April 2021 I commenced an investigation into the death of Eldine Loretta Lashley aged 82 years. The investigation concluded at the end of the inquest on 2nd September 2021. The conclusion of the inquest was that Mrs Lashley died from: 1.a Subdural Haematoma; II. Advanced dementia, Type 2 diabetes mellitus, Chronic kidney disease, Hypertension A short form conclusion of accidental death was arrived at.
4	**CIRCUMSTANCES OF THE DEATH**

	On 6th April 2021 Mrs Eldine Loretta Lashley suffered an unwitnessed fall at a care home sustaining a subdural haemorrhage. Despite medical intervention Mrs Lashley deteriorated and died at home on 14th April 2021.
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 Lashley's mobility care plan was not updated in response to developments in her care needs – specifically the need to observe her more frequently than once per hour. 2. Progress notes created by nursing and care staff did not accurately reflect the frequency of checks carried out on Mrs Lashley.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 **11th November 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 Lashley and to 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	**[DATE] 16th September 2021 [SIGNED BY CORONER]** GRAEME IRVINE