Mr C Morris
HM Coroners Office
1 Mount Tabor St.
Stockport
SK1 3AG

Date: 29th September 2020

Re: Reg 28 dated 07.09.2020 Re Peter Howarth

Dear Mr Morris

Thank you for your correspondence.

We had previously received a REG 28 on 28.11.19 relating to falls and have put extra measures in place to review falls on a weekly/monthly basis as a result.

Below is a time line of events:

Death of Andrew Hogg	06.05.19
Inquest of Andrew Hogg	06.10.19
REG 28 received	26.11.19
Manager Meeting	28.11.19
Reply to Coroner	02.01.20
Death of Peter Howarth	10.09.19
Inquest of Peter Howarth	07.07.20

At the Manager meeting on the 28th November 2019 we discussed the new procedures for reviewing falls in all Borough Care homes.

Managers must now complete a weekly falls analysis and detail all actions taken. If a resident has more than 2 falls in any period of 2 weeks a referral must be made to their GP or to the falls clinic.

Managers must also complete a monthy review to ensure the safety of all residents and hilight any trends that may be contributing to the falls within the home.

As you can see from the timeline above these extra measures were implemented after the inquest of Andrew Hogg. The additional measures were therfore not in place when Peter Howarth fell, but were in place before the inquest into the death of Peter Howarth.

All these measures have been discussed with CQC and our policy has been updated to reflect the extra analysis and actions.

I have attached the previous correspondence with the Coroner in relation to the earlier REG28, re falls. I hope this meets with your approval.

Please do not hesitate to contact me if your require any further information.

Regards

[redacted]

[redacted]
Head of Care