Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Glenholme Holdingham Grange Care Home

1 CORONER

I am Paul COOPER, HM Assistant Coroner for the area of Lincolnshire

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 05/03/2019 I commenced an investigation into the death of Donald George ELLIOTT aged 88. The investigation concluded at the end of the inquest on 07 February 2020. The conclusion of the inquest was:

I a Intracranial Haemorrhage

I b

I c

II Parkinson's Disease, Dementia, Heart Failure.

4 CIRCUMSTANCES OF THE DEATH

The deceased was cared for at Glenholme Holdingham Grange, Whittle Road, Holdingham, Sleaford. Following at least one fall in the home (that was witnessed) on 31st January 2019 as a result of which on the balance of probabilities the deceased hit his head on the floor (although this was not witnessed) .The deceased was taken to hospital where he stayed until 9th February 2019. He was then discharged back to the home and was nursed in bed until he died on 22nd February 2019.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

1. Please confirm the level of staffing present on 24/01/2019 and 31/01/2019 at the time the deceased was recorded as falling.

2. Is the Care Home able to evidence and demonstrate on both dates they complied with Regulation 18 Health and Social Care Act 2008 as to:

a) Deploying enough suitably qualified competent and experienced staff and,

b) That those staff received the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.

3. This report is raised due to the contradictory evidence filed in the Inquest for and on behalf of Glenholme Holdingham Grange Care Home and to ascertain why the coronial service was only notified the day before the Inquest why 2 witnesses formerly engaged by the Care Home failed to attend the inquest under summons. An explanation of which is required as to what efforts and resources were deployed to locate them by a manager/director.

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 08 April 2020. 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]

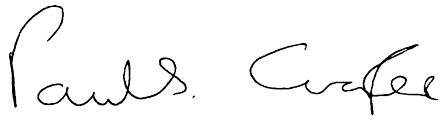
……

……

I am also under a duty to send 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



Paul COOPER
HM Assistant Coroner for
Lincolnshire
Dated: 12 February 2020