REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Lawrence Tomlinson, Chief Executive, LNT Software Helios 47 (owners of Herries Lodge Care Home, Sheffield)**
1	**CORONER** Christopher Dorries, HM Senior Coroner for South Yorkshire West.
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 the 22nd March 2013 I commenced an investigation into the death of Mrs May Gibson. The investigation concluded at the end of the inquest on 22nd of August 2013. The conclusion of the inquest was that Mrs Gibson had died from a head injury following a fall and I found that given the information that was known or should have been known about Mrs Gibson there was a gross failure to take appropriate measures which would have been likely to prevent or minimise such a fall and thus that Mrs Gibson's death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Gibson was subject to a detailed community care assessment by Sheffield Social Services in mid 2012 and it was clear that she needed residential care. This assessment identified the risk of falling and poor mobility as major issues. However a pre-admission assessment by the then manager of Herries Lodge Care Home did not identify or plan to mitigate the same risks, although eight previous falls were noted. The City Council assessment was sent to Herries Lodge but was not taken into account. The care plan drawn up for Mrs Gibson did not address relevant issues that were known or should have been known. When Mrs Gibson had falls within Herries Lodge the care plan was not updated and on two occasions did not even carry a note of the fall although accident forms were completed. Falls risk assessment forms were completed from time to time but did not correctly assess Mrs Gibson, nor were the requirements that were set out upon the form followed by either of the staff members involved. Mrs Gibson subsequently had a significant fall within her room on 21st March 2013 sustaining fatal injuries.
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: -- 1) the failure to obtain the community care assessment and to take proper account of this in developing a care plan;

	2) the failure to make a proper pre-assessment, or query the differences in assessment with the City Council, or to make a further assessment upon admission; 3) the failure to develop a care plan which recognised Mrs Gibson's needs adequately, whether initially or by review after she had fallen on several occasions within the Home; 4) the failure to risk assess adequately, taking account of all information that was known, let alone information that should have been known; 5) the failure to develop a risk reduction plan when mandated by the risk assessment, even as it was actually completed; 6) the failure to take available preventative measures given the information that was known or should have been known; 7) although not causative of Mrs Gibson's death, there was confusion amongst staff as to the circumstances in which an ambulance should be called as opposed to contacting the out of hours GP service; 8) whilst not explored at the inquest, it may be that no managerial action was taken on the accident report forms to ensure that they were properly followed up with risk or repeat incident prevention strategies identified; 9) the evidence as a whole gave a picture of an establishment that had no cohesive management at the time, with staff who were caring but insufficiently trained and supervised.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and the company 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 Friday 25th October 2013. I may extend this period upon application. 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 deceased's family [redacted] Sheffield City Council (adult protection unit) I have also sent a copy to the Care Quality Commission who may find it useful or of interest. 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 at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**[DATE]** **[SIGNED BY CORONER]** 30th August 2013 *Christopher Dorries*