REGULATION 28: REPORT TO PREVENT FUTURE DEATHS(1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted] Associate Director of Consumer Relations and Legal Affairs. 2. The Manager, Floron Residential Home, 236-238 Upton Lane, Forest Gate, Newham, E7 9NP
1.	I am Chinyere Inyama, 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 Coroner's and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**INVESTIGATION and INQUEST** On 14th May 2012 I commenced an investigation into the death of Douglas Grey then aged 72 years. The investigation concluded at the end of the inquest on the 25th September 2013. I concluded the inquest with a narrative, the medical cause of death being right sided pneumonia due to an acute subdural haematoma.
4.	**CIRCUMSTANCES OF THE DEATH** 1. The deceased had been in a residential home since 2008 and, as a result of pressure sores after discharge from hospital, was given an inflatable mattress which was placed on top of the original mattress on his bed. 2. There were no cot sides or other safety features used. 3. He suffered a fall from his bed on the day the inflatable mattress was installed. Staff removed the mattress as they were concerned over it 'slipperiness'. He then suffered a second fall a few days later. The mattress was then advised to be removed by the district nurse. 4. A few days after the second of the falls he became unconscious

	and had to be transferred to hospital where he died, despite treatment, in the early hours of the 5th May 2012.
5.	**CORONER'S CONCERNS** During the course of the inquest, evidence revealed matters giving rise to concern. In my opinion there is 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. Evidence was given at the inquest that there was no clear written procedure or policy in place to ensure notification to the district nurses of delivery of equipment they had assessed as being needed, correct installation of that equipment and review of the equipment's performance. 2. Evidence was given at the inquest that despite a clear written policy on recognising and reporting faults in equipment delivered for residents, carers did not appear to recognise the faulty nature of the inflatable mattress and act in accordance with the written policy of the home.
6.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you/or your organisation have the power to take such action. For recipient (1) it is clear a system to carefully monitor installation and performance of equipment recommended by district nursing teams should be set up. In addition, the operation of the system should be audited on a regular basis since potential consequences of absence of or poor operation of such systems are potentially so serious. For recipient (2) it is clear that the operation of the practice and procedures set down by written protocols need to be audited clearly and regularly.
7.	You are under a duty to respond to this report within 56 days of the date of this report namely by 3rd December 2013. 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 Interested Person [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 of the publication of your response by the Chief Coroner.
9.	**3rd October 2013.**