REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive Officer, Borough Care Limited, 9, Acorn Business Park, Heaton Lane, Stockport SK4 1AS**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 7th January 2014 I commenced an investigation into the death of **Doris Taylor** dob **3rd October 1931**. The investigation concluded on the 31st March 2014 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a Pneumonia and multi organ failure 1b Fracture neck of femur (operated) and II Meningioma, intracranial haemorrhage and hypertension.**
4	**CIRCUMSTANCES OF THE DEATH** On the 20th November 2013 she was admitted to Marbury House Care Home due to decreased mobility and pains in her back. She was assessed as being at high risk of falling. During the course of her stay she suffered 3 separate falls. It would appear that the second of these falls was due to a defective door-closer which caused the door to close knocking Mrs Taylor over. The senior member of staff who attended the inquest to give evidence was unaware of the need to report such incidents to the Health and Safety Executive and further stated that she was not trained as to which matters are reportable under RIDDOR.
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. Staff training should include a full and clear understanding as to what constitutes a reportable incident and the managers should be aware of their duty to report such. 2. The door-closers on all doors in such an establishment should be in a safe working condition, and of such 'strength' as to be efficient in causing the door to close yet at the same time not so 'strong' as to make it dangerous as they close (as to knock over the person as happened to Mrs Taylor).

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **5th June 2014**. 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 namely [redacted] **(daughter of the deceased)**. 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	**9 April 2014** **John Pollard, HM Senior Coroner**