Regulation 28: Prevention of Future Deaths report

John William BIRD (died 28.05.14)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Registered Care Home Manager** **Hawthorn Green Care Home** **82 Redmans Road** **Stepney** **London E1 3AG**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 2 June 2014 I commenced an investigation into the death of John William Bird, aged 92 years. The investigation concluded at the end of the inquest earlier today. I made a determination that Mr Bird's death came about as the result of an accident, when he fell in his care home on the evening of Tuesday, 29 April 2014. I recorded his medical cause of death as: 1a pneumonia 1b subdural haematoma 2 dementia and general frailty

4	**CIRCUMSTANCES OF THE DEATH** Mr Bird fell at around 11.20pm, having gone to bed a couple of hours earlier. A carer was close by and immediately came to his room to assist. He was taken to hospital shortly thereafter, but later died from the injury sustained.
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. You were unable to detail in court the entirety of the falls risk assessment you had undertaken for Mr Bird, because you did not bring the record of the risk assessment to the inquest, despite the nature of Mr Bird's death and a written request from my coroner's officer. However, you were confident that you had assessed Mr Bird as being at very high risk of falls, as a consequence of his level of cognitive impairment coupled with his ability to walk without assistance. (This is, of course, a very difficult combination.) Yet the carer who found Mr Bird after his fall, did not appear to have any familiarity with risk assessments. Even allowing for possible language difficulties (the carer is not a native English speaker), he assessed Mr Bird's ability to mobilise unaided as "fine", and did not see any particular risks for him. When I put the carer's evidence to you in court, you told me that he *should* know about the risk assessments. You later agreed in evidence that, as manager of the care home, it is your responsibility to ensure that all staff are familiar with risk assessments and the resulting care plan for each resident.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and Sanctuary Care Limited 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 15 December 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted] son of John Bird [redacted] • Chief Executive, Sanctuary Care Limited, Cameo House, Chamber Court, Worcester WR1 3ZQ 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 16.10.15