## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

I make this repo and regulations and regulations on 30 Decemb WELLS, AGE 7 September 201 Traumatic intrau Accidental Dear Accidental Dear and treatment for wheeled frame in place. On 21 staff she had crobell on the wall hospital, returne fall. Her condition of the cour ln my opinion the circumstances in The MATTERS  The MATTERS  (1) A light switch photograph). More to the light could have bee taken of the bear to the light.
S LEGAL POWERS  'S LEGAL POWERS  report under paragraph 7, Schedule 5, fons 28 and 29 of the Coroners (Investigations 28 and 29 of the Coroners (Investigations 28 and 199 of the Coroners (Investigation 2014. The conclusion of the inquest witracerebral haemorrhage b) fall with hoeath.  ANCES OF THE DEATH  S CONCERNS  S CONCERN are as follows. — witch was positioned on the wall beside her bed where so fage, frail walked with the aid of a 3 wheeled frar bed on the switch on the in a bedroom do not support this. Further archer beautich
CORONER'S LEGAL POWERS  CORONER'S LEGAL POWERS  CORONER'S LEGAL POWERS  I make this report under paragraph 7, Schedule 5, of the Coroners and Justic and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 INVESTIGATION and INQUEST  INVESTIGATION and INQUEST  On 30 December 2013 I commenced an investigation into the death of ANN I WELLS, AGE 77 YEARS. The investigation concluded at the end of the inquesty was medical cause of death: Traumatic intracerebral haemorrhage b) fall with head injury; and short-form Accidental Death.  CIRCUMSTANCES OF THE DEATH  The MATTERS OF CONCERNS  During the course of the inquest the evidence revealed matters giving rise to In my opinion there is a risk that future deaths will occur unless action is take circumstances it is my statutory duty to report to you.  The MATTERS OF CONCERN are as follows. –  The MATTERS OF CONCERN are as follows. –  The MATTERS OF CONCERN are as follows. Find with scoliosis, osteoarthritic temor and walked with the aid of a 3 wheeled frame. Evidence was given the could be a
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.  INVESTIGATION and INQUEST  On 30 December 2013 I commenced an investigation into the death of ANN MARY WELLS, AGE 77 YEARS. The investigation concluded at the end of the inquest on 2 September 2014. The conclusion of the inquest was medical cause of death: 1a) Traumatic intracerebral haemorrhage b) fall with head injury; and short-form conclusion. Accidental Death.  CIRCUMSTANCES OF THE DEATH  CIRCUMSTANCES OF THE DEATH  Mis Wells was resident on Sandringham Ward, Julian Hospital, Norwich (providing carre and treatment for those with complexities in later life) and was mobile with the aid of a 3 wheeled frame. Mrs Wells was assessed as being at risk of falls. A Falls Carre Plan was in place. On 21 November 2013 Mrs Wells was found on the flight. There is a light switch and a call bell on the wall beside her room to switch on her light. There is a light switch and a call bell on the wall beside her bed where she was sleeping. Mrs Wells was taken to hospital, returned to Julian Hospital and then readmitted to hospital. She had another fall. Her condition deteriorated and Mrs Wells was the Not bells was the Not bells was the Not bells was the Not bells was the not hospital statutory duty to report to you.  The MATTERS OF CONCERN are as follows. —  (1) A light switch was positioned on the wall beside Mrs Wells' bed (see attached photograph). Mrs Wells was 77 years of age, frail with scollosis, osteoarthritis and a temor and walked with the aid of a 3 wheeled frame. Evidence was given that this could have been reached by Mrs Wells when in a sitting position in bed. Photographs taken of the bedroom do not support this. Further the emergency call switch is situated
I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 200 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.  INVESTIGATION and INQUEST  On 30 December 2013 I commenced an investigation into the death of ANN MARY WELLS, AGE 77 YEARS. The investigation concluded at the end of the inquest on 2 September 2014. The conclusion of the inquest was medical cause of death: 1a) Traumatic intracerebral haemorrhage b) fall with head injury; and short-form conclusion Accidental Death.  CIRCUMSTANCES OF THE DEATH  Mrs Wells was resident on Sandringham Ward, Julian Hospital, Norwich (providing card and treatment for those with complexities in later life) and was mobile with the aid of a swheeled frame. Mrs Wells was assessed as being at risk of falls. A Falls Care Plan was in place. On 21 November 2013 Mrs Wells was found on the floor of her room. She tolk staff she had crossed her room to switch on her light. There is a light switch and a call bell on the wall beside her bed where she was sleepling. Mrs Wells was taken to hospital, returned to Julian Hospital and then readmitted to hospital. She had another fall. Her condition deteriorated and Mrs Wells died on 28 December 2013.  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) A light switch was positioned on the wall beside Mrs Wells' bed (see attached photograph). Mrs Wells was 77 years of age, frail with scoliosis, osteoarthritis and a tremor and walked with the aid of a 3 wheeled frame. Evidence was given that this could have been reached by Mrs Wells when in a sitting position in bed. Photographs taken of the bedroom do not support this. Further the emergency call switch is situated
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Date: 11 September 2014  Jacqueline Lake Senior Coroner for Norfolk	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.	I am also under a duty to send the Chief Coroner a copy of your response.	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:  (daughter)	COPIES and PUBLICATION	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.	You are under a duty to respond to this report within 56 days of the date of this report, namely by 10 November. I, the coroner, may extend the period.	YOUR RESPONSE	In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.	ACTION SHOULD BE TAKEN	this particular room.

