	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Department of Health **2.** Bury MBC **3.** Care Quality Commission **4.** Messrs. Latimer Lee Solicitors on behalf of Oak Lodge Care Home **5.** Family of the deceased **6.** Chief Coroner
1	**CORONER** I am Simon Nelson, HM Senior Coroner for the Coroner area of Manchester North
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 the 7th April 2014 I commenced an investigation into the death of **Anne Horner** for whom the cause of death had been given as being that of 1a) Traumatic Acute Subdural Haemorrhage with Renal Cell Carcinoma with Lung Metastases; Anticoagulation Therapy, whilst not causative of death, being contributory factors under 2. At an Inquest at the Rochdale Coroners Court Heywood on the 22nd January 2015, the following conclusion was reached 'against a background of increasing frailty of health and use of anti-coagulation therapy Anne Horner died at The Salford Royal Hospital on the 25th March 2014 from a traumatic head injury precipitated initially by inadvertent impact with a toilet door which was being opened at Oak Lodge Care Home at approximately 05:15hrs that day but which may have been aggravated by subsequent trauma following her collapse at approximately 09:40hrs that day whilst at the Care Home'.
4	**CIRCUMSTANCES OF DEATH** **As above**
5	**<u>CORONER'S CONCERNS</u>** 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 deceased had been a resident at Oak Lodge Nursing Home for approximately 6 weeks prior to her death during which time she was able to access and use bathroom facilities that were close to the bedroom which she occupied. 2. At approximately 02:30hrs on the 6th March 2014 whilst Mrs Horner was within the toilet cubicle within the bathroom she sustained a minor head injury when the door to the cubicle struck her

	head as it was being opened by a Health Care Assistant who was undertaking room checks. 3. At approximately 05:30hrs on the 25th March 2014 Mrs Horner was involved in a virtually identical incident, again whilst sitting within the toilet cubicle. Sadly later that morning she was found unresponsive and notwithstanding her transfer to the emergency department at Salford Royal Hospital, she was diagnosed as having an unsurvivable brain injury. 4. The evidence at Inquest confirmed that the bathroom facility which included the toilet cubicle was constructed in or about 1988 in compliance with the relevant Planning Permission and Building Regulations. I accept that the facility had been used on many previous occasions without incident. The fact however that a resident sustained injury on two separate occasions within a period of 6 weeks gives rise to concern. I anticipate that there are many establishments within England and Wales where toilet facilities are not dissimilar to those at Oak Lodge Nursing Home. I understand that separate guidance in relation to disabled toilet design suggests doors that open outwards to facilitate access if someone falls behind the door. Whilst photographic images produced at Inquest suggested adequate door clearance for a resident sitting normally on the toilet, that would not be so for an individual resident who sat / was slumped forward.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to consider legislation that would prevent fatalities occurring in similar circumstances and I believe each of you respectively 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 8th April 2015. 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:- **1.** Department of Health **2.** Bury MBC **3.** Care Quality Commission **4.** Messrs. Latimer Lee Solicitors on behalf of Oak Lodge Care Home **5.** Family 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 from. He may send a copy of this report to any person who he believes may find it usefulor 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	Date: 11th February 2015 Signed: