REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Lapal House & Lodge Care Home** **2. Care Quality Commission (CQC).**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of Black Country.
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 22nd of December 2014, I commenced an investigation into the death of Stanley Edward Ward. The investigation concluded at the end of the inquest on 5th February 2014 February 2014. The conclusion of the inquest was a narrative conclusion: Mr Ward suffered a fall at his residential care home on 29 November 2014. Mr Ward underwent basic checks by staff at the home overnight and no concerns were raised. The following morning at 6am he was noted to be unresponsive and had vomited. Paramedics were called and he was taken to the Queen Elizabeth Hospital where it was found that he had suffered a devastating head injury, from which he died. The head injury is likely to have been caused by the fall on 29 November and warfarin therapy is likely to have exacerbated the bleed.
4	**CIRCUMSTANCES OF THE DEATH** 1. Mr Ward was an 85-year-old resident of the Lapal House and Lodge care home. He was admitted to the Home on 17 November 2014 for two weeks respite care and was due to return home on Sunday, 30 November. He had a past history of Parkinson's disease and was on warfarin therapy. 2. On the evening of the 29 November 2014 he suffered an un-witnessed fall at the residential car home. It appears he may have slipped off the toilet and knocked his head when he hit the ground. No external injury or visible signs of blood loss were noted by staff. The staff that treated him were trained in first aid only but were not qualified to perform neurological observations or are medically qualified. For example, no tests were performed in relation to checking the pupils. In addition, no referral was made to the GP or paramedics called despite Mr Ward telling staff his wife would normally call the paramedics if he had fallen at home. 3. The staff checked on Mr Ward during the night and he appeared to be sleeping (they heard him snoring). The following morning at 6am he was found unresponsive and had vomited. Paramedics were then called and he was taken to Queen Elizabeth Hospital, Birmingham where a CT confirmed a left subdural haematoma with mass effect deemed inoperable due to co-morbidities and frailty. Mr Ward was treated symptomatically and passed away at 23:10pm on the 11 December 2014.

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) Mr Ward was an elderly patient who was at risk of falling and who was on long term warfarin. There is an increased risk of bleeding to elderly patients on warfarin who sustain a head injury. The care staff who attended to Mr Ward appeared to be unaware of the increased risk of bleeding even though there weren't visible injuries. (2) During the inquest evidence was given in relation to the fall risk assessment and the policy adopted. However, there was no clear policy or training highlighted in dealing with patients who are on anti-coagulant therapy. In addition, it wasn't clear the procedure for the escalation and referral of patients to qualified medical staff in the event of a fall.
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 3 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, Mr Ward's family. 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	**5 February 2015**