REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Director of Nursing, Risedale Estates Limited** **2. Care Quality Commission**
1	**CORONER** I am Paul O'Donnell assistant coroner, for the coroner area of Cumbria
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 December 2014 an investigation was commenced into the death of Mrs Violet Cloudsdale, aged 99 years old. The investigation concluded at the end of the inquest on 16th September 2015. The conclusion of the inquest was accidental death. The medical cause of death was: 1.a Bronchopneumonia 2. Fractures of the left tibia, right humerus and left radius. Cerebrovascular disease. Diabetes mellitus. Hypertension.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Cloudsdale was a resident at Lonsdale Nursing Home, Barrow-in-Furness. On 11th December 2014, she fell whilst unattended from a seated position in a stationary wheelchair and sustained fractures to the left tibia; right humerus and left radius. She died 5 days later from bronchopneumonia whilst being treated for her injuries at Furness General Hospital, Barrow-in-Furness.
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) It was confirmed in evidence by [redacted] that: a) Mrs Cloudsdale would have been less likely to have fallen if the lap-belt which was fitted to the wheelchair had been fastened; b) No risk assessment had been undertaken as to whether the lap-belt should generally have been utilised; c) No attempt had been made to identify whether Mrs Cloudsdale or her family would have indeed consented to the lap-belt being fastened to enhance her feeling of safety or security; d) There was a concern that utilising lap-belts may be construed as applying an unlawful restraint; e) Guidance on the use of lap-belts is unclear.

	A thorough review of your procedures with regard to the use of lap belts fitted to wheel chairs is required.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 20th November 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: [redacted] (daughter of the deceased). I have also sent it to the Care Quality Commission who may find it useful or of interest. 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	**Signed:**  **Paul O'Donnell** **Dated: 25th September 2015**