

## Thomas Ralph Osborne Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Strategic Director, Excel Care
1	CORONER
	I am Thomas Ralph Osborne, Senior Coroner for Milton Keynes .
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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a>
3	INVESTIGATION and INQUEST
	On 16/01/2017 I commenced an investigation into the death of Ida Jean Toole, ages 82. The investigation concluded at the end of the inquest on 2 <sup>nd</sup> May 2017. The conclusion of the inquest was that she died as the result of an accident.
4	CIRCUMSTANCES OF THE DEATH  Mrs Toole suffered an unwitnessed fall at Water Hall Care Centre on the 10th January 2017 and suffered a head injury. She died at Milton Keynes Hospital on the 14th January 2017. Her cause of death was given as 1a) Pneumonia 2) Acute on Chronic Subdural Haemorrhage
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. –
	During the course of the evidence I was told that Mrs Toole did not have a sensor mat alongside her bed despite having been assessed as a high risk of falling. The reason for this, I was told, was due to the fact that Mrs Toole had mental capacity. The policy for the provision of sensor mats to high risk residents should be urgently reviewed.

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 27 <sup>th</sup> June 2017. 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  Care Quality Commission  The family of Mrs Toole
	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	Signature Tom Osborne, Senior Coroner for Million Keynes