REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Ms Jane Pickering, Chief Executive, Eldercare, 847 Burnley Road, Loveclough, Rawtenstall, Lancashire BB4 8QL **2.** Ms Donna Hall CBE, Chief Executive, Wigan Council, Town Hall, Library Street, Wigan WN1 1YN **3.** The Right Hon. Sajid Javid MP, Secretary of State for Community and Local Government **4.** The Right Hon Jeremy Hunt MP, Department of Health, 2 Marsham Street, London SW1P 4DR **5.** Sir David Behan CBE, Chief Executive, CQC, 151 Buckingham Place Road, London SW1 9SZ
1	**CORONER** I am M Jennifer Leeming, HM Senior Coroner for the Coroner Area of Manchester West.
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 the 7th day of April 2017 I commenced an investigation into the death of Helen Theresa Cannon, 87 years, born the 8th July 1930. The investigation concluded at the end of the Inquest on the 3rd of August 2017. The medical cause of death was:- Ia Myocardial Infarction Ib Haemorrhage Associated with Pelvic Fracture II Cardiac Failure The conclusion of the Inquest was Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** On the 2nd of April 2017 Helen Theresa Cannon fell at her home address, [redacted] Wigan. She was a client of Eldercare, which provides a national monitoring and response service. Emergency responders from that service attended to assist in getting Mrs Cannon up from the floor, which they did using a lifting cushion, as Mrs Cannon was otherwise unable to get up.

5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. The emergency responders did not seek medical or paramedic assistance for Mrs Cannon because she was complaining of suffering aching rather than pain. It transpired that Mrs Cannon had suffered internal haemorrhage as a result of a pelvic fracture sustained in her fall, and this led to her death two days later. Evidence was heard at the Inquest from a Consultant Trauma and Orthopaedic Surgeon that in the circumstances it would have been good practice to have obtained medical or paramedic assistance for Mrs Cannon. 2. Following Mrs Cannon's death Eldercare carried out an investigation. The investigation was flawed in that it did not address clear inaccuracies in the Moving and Handling Risk assessment checklist completed by one of the Emergency Responders, nor did it discover that the other Emergency Responder attending did not understand that he was agreeing with the accuracy of the information recorded on the checklist when he countersigned it. It was his belief that he signed the checklist simply to agree that he had been present.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 10th October 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:- [redacted] 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	**Dated** **16th August 2017**	**Signed** **Professor Jennifer M Leeming,** **HM Senior Coroner**