VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

Assistant Coroners
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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: **1. Carlton House Rest Home, MacLeod Pinsent Care Homes Ltd** **2. [redacted] Compliance Manager** **3. [redacted], Manager, Carlton House Rest Home**
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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 3rd October 2017 I commenced an investigation into the death of Sheila ROSS. The investigation concluded at the end of the inquest on 21st December, 2017. The conclusion of the inquest was **ACCIDENTAL DEATH (TO WHICH NEGLECT CONTRIBUTED)**
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
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) Mrs Ross became a resident at Carlton House Rest Home in October 2014

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	following having fallen and fractured her hip, yet even at this early stage a falls risk assessment was note completed for her. The years went by, and there were no falls but on the 9th December 2016 Mrs Ross had what was described in the GP's letter as a fall. The Rest Home Manager described it as 'slip' - 'she slipped off the edge of the bed'. This is not uncommon but in the absence of any falls over for over two years it's worrying and should have triggered a falls risk assessment but it didn't. In July of 2017 Mrs Ross was admitted to hospital very unwell with sepsis due to coli cystitis. On her return to the Rest Home she was less well and more agitated, her sleep which had always been of irregular pattern became worse and she was wandering more. Physically, she apparently didn't need a stick but her behaviour was such that it was believed that she lacked mental capacity – an application was made and she was placed on a Deprivation of Liberty Safe Guarding Order from the 23rd August 2017. The assessments in connection with this highlighted her vulnerability and the fact that she needed 24 hour care and yet there was still no falls risk assessment carried out. By the time she had the fatal fall on the 17th September when she fell down a flight of stairs (which led to a floor on the Rest Home that she had no need to visit) she still had no falls risk assessment. It is, of course, entirely possible for falls to occur even in the best regulated of situations with all paperwork properly in place. However, if a falls risk assessment had been carried out it would have highlighted Mrs Ross' inability to make any assessment of her own personal safety and there is a possibility that this fall could have been prevented. Since this catastrophic injury there has been significant changes in personnel at the Rest Home and I have no doubt that steps have been initiated to ensure that all residents have the appropriate risk assessments and I also believe that the Inquest itself will be a catalyst to speed this process up.
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 14th March 2017. I, the coroner may extend the period. Your response must contain details of action taken or proposed to be taken, setting

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	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 1. [redacted] 2. [redacted] 3. The Clinical Commissioning Group 4. The Care Quality Commission 5. General Practitioner, [redacted] 6. Secretary of State for Health, Department of Health 7. Simon Stevens, Chief Executive, NHS England 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	**Date: 21st December 2017 SIGNED BY:** V. Hamilton Deeley **Senior Coroner Brighton and Hove**