	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Baycroft Care Homes & Senior Villages, Grays farm Road, Orpington, Kent BR5 3BD**
1	**CORONER** I am Jacqueline Devonish, assistant coroner, for the coroner area of South London
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 2 November 2017 I commenced an investigation into the death of Doris McCarthy, aged 92 years. The investigation concluded at the end of the inquest on 6 July 2018. The conclusion of the inquest was that Doris McCarthy died from natural causes as a result of a pulmonary embolism, with an underlying subdural haemorrhage caused by recurrent falls.
4	**CIRCUMSTANCES OF THE DEATH** Mrs McCarthy became a resident of Baycroft Orpington on 19 September 2017 due to her reducing mobility, declining memory, recurrent falls and inability to take care of her personal needs in her own home. She had been placed as a resident directly following an inpatient stay in hospital, during which time she was identified as having a subdural haematoma, and at high risk of falls. The General Manager, during the period of residence, gave evidence at inquest that Baycroft is a state of the art facility with sensors and alarms alerting staff of resident movements. This included a call bell system activated by sensors both in beds and chairs, and falls wrist watches. The General Manager identified two 'fall' incidents whilst in the home on 20 and 28 September 2017. On both occasions Mrs McCarthy slid from her chair but the sensor system did not alert staff. The evidence given was that the system had frequent outages, and that it was not possible know when such an outage had occurred.
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) The sensor system outages might still exist, leaving residents vulnerable due to staff not being alerted to a fall (2) Steps taken to safeguard residents who are known to slide when placed to sit in a chair.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 3 September 2018. 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 [Gail [redacted] I have also sent it to [redacted] 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	**9 July 2018** Jacqueline Devonish