REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care** **AT** **The Department of Health & Social Care, 39 Victoria St, London, SW1H OEU**
1	**CORONER** I am Emma Whitting, Assistant Coroner, for the Coroner area of Coventry (sitting in Warwickshire).
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 4 April 2018 an investigation was opened into the death of Ruth Marian Perkin. The investigation concluded at the end of the inquest on 11 July 2018. The conclusion of the inquest was Accident.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was admitted to Kenilworth Grange Care Home under a Discharge to Assess (2DA) scheme from Warwick Hospital on 9 February 2018. Whilst at the home, during the evening of 11 February 2018, she suffered an unwitnessed fall; although she was not thought to have suffered any injuries at the time, the following day she was noted by a visiting GP to have a shortened and externally rotated right leg and to be experiencing a lot of pain on rotation of the right hip. She was subsequently re-admitted to Warwick Hospital where she underwent a right dynamic hip screw repair. Although she made an initial recovery, her condition deteriorated thereafter, and she passed away on 29 March 2018; her death being certified at 9.00am that day.
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 could 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) On admission to the Care Home, Mrs Perkin was assessed as follows: **Current Situation** "Ruth mobilises with a Zimmer frame, supported by one staff member. She is at risk of falls MFRA tool for falls is in place". **Expected Outcome** "To reduce the risk of falls for Ruth as much as possible"

	(2) I was informed at the inquest that her MFRA risk of falls score at the time of admission was 21. (3) On 10 February 2018, only the day after her admission, Mrs Perkin was found by staff on the floor of the corridor outside her room having apparently slipped from the chair she had been sitting in. An incident form was completed and her risk of falling was reviewed resulting in an increased MFRA score of 29. (The highest level is apparently 35). On 11 February at around 08.30 pm during the evening, she was found on the floor again – this time in the lounge at the Care Home and it appeared that she had again fallen from a chair in which she had been sitting. The following morning, she complained of pain and was admitted to hospital where she was found to have suffered a right neck of femur and it was during that admission that she contracted pneumonia and sadly passed away. (4) I was informed by the Care Home Manager that if Mrs Perkin not suffered a fracture and had been returned to the care of the Care Home after her second fall, she would have suggested to the hospital that, in view of Mrs Perkin's tendency to act in disregard of care instructions, she was in fact most likely in need of 1:1 care. (5) I was informed that for the 20 residents at the Care Home there are 5 staff on duty during the day, reducing to 3 staff at night, and my concern is that Mrs Perkin's discharge to the Care Home under the D2A scheme, when her needs were still being assessed, actually placed her at an increased risk of falls and death as a result.
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 14 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 daughter, [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	**DATE: 20 July 2018** **SIGNED BY EMMA WHITTING**