East London Coroners
MISS N PERSAUD
SENIOR CORONER
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REF:9075

12th March 2019

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Justin Hutchins, Chief Executive Officer, The Kind Care Company, Southgate House, Archer Street, Darlington, County Durham, DL3 6AH**
1	**CORONER** I am Miss N Persaud Senior Coroner for **East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 18th August 2018 I commenced an investigation into the death of Mr Frederick Raymond BROOKER. The investigation concluded at the end of the inquest on the 12th March 2019. The conclusion of the inquest was: *Mr Frederick Brooker had sustained multiple falls from his wheelchair, whilst residing in a Care Home. A fall from the wheelchair on the 1 July 2018 had resulted in a hospital attendance for a head injury. Following this fall, the care plan was not updated; the wheelchair assessment review was not updated and Mr Brooker was not encouraged to wear the seat belt. He sustained a further fall from his wheelchair on the 10 July 2018. He required hospital admission for a further head injury. A subdural haemorrhage was identified at this time. He died from this head injury on the 14 July 2018.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Brooker was admitted to the Bakers Court Residential Care Home on the 26th January 2018. He required the use of a wheelchair to mobilise around the Care Home. The General Practitioner noted on the 16th March 2018 that Mr Brooker had fallen from his wheelchair when reaching to pick up a book from the floor. The General Practitioner was told at that time that similar slides from the wheelchair had happened several times before. At this time, Mr Brooker did not sustain any injury and the GP noted a low impact fall. Mr Brooker was strongly encouraged to ask for assistance if something fell to the floor. No other strategies were identified, at that time, to reduce the risk of further falls. On 20th March 2018 the GP noted that Mr Brooker had slid from his wheelchair twice in the last few days. The falls were again noted to be low impact and had occurred whilst he was leaning forward reaching for

	items. On the 5th April 2018 Mr Brooker fell again from his wheelchair. At this time he was noted to have sustained a head injury and paramedics were called. On the 29th May 2018 Mr Brooker fell again from his wheelchair. No injuries were noted at this time. On the 1st July 2018 Mr Brooker fell again from his wheelchair and at this time sustained a head injury. He was taken to Newham University Hospital where a CT scan was carried out. Mr Brooker was on Warfarin and therefore at high risk of bleeding from head injury. No bleed was found at this time and he was discharged back to the home on the 1st July 2018. The Falls Risk Assessment was updated on the 1st July 2018 and it was noted that Mr Brooker remained at high risk of falling. There was however no review of the care plan in place to address his risk of falling; there was no review to his wheelchair assessment; there was no documented need for the seatbelt to be used by Mr Brooker; there was no evidence of any encouragement for Mr Brooker to use the seatbelt. Mr Brooker's son raised concerns with the Care Home on the 1 July 2018 in relation to the multiple falls. In response to these concerns the Care Home staff agreed to liaise with wheelchair services. No action was however taken by the Care Home staff to liaise with wheelchair services. On the 10th July 2018, Mr Brooker suffered a further fall from his wheelchair. He sustained a head injury and was returned to Newham University Hospital. At this time, it was noted that Mr Brooker had sustained a catastrophic traumatic bleed. He passed away from the head injury on the 14th July 2018.
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) Despite Mr Brooker sustaining multiple falls of increasing severity, no reasonable measures were taken by the Care Home staff to address the high risk of falling. Risk assessments were completed. The high risk was recognised, but there were no care plans to address the identified risk. (2) There were no steps taken by the Care Home staff to report the multiple falls to the London Borough of Redbridge who were commissioning Mr Brooker's care. There was no referral to wheelchair services to consider whether the wheelchair provided for Mr Brooker was appropriate for him. There was no referral to occupational therapy for a review of Mr Brooker's mobility. Following the falls, there was no evidence of Mr Brooker being encouraged to use his seat belt. (3) An investigation took place into a fall on the 15th March 2018. No further investigations were carried out by the home into the subsequent falls, including those falls resulting in injury. Senior staff were not, therefore, always aware of the circumstances of each fall. They were therefore not able to identify the optimum means of attempting to reduce the risk of further falls. (4) There was reliance on the fact that Mr Brooker had mental capacity. This should not override the importance of care planning. Attempts should have been made to plan care to keep Mr Brooker safe. He should have been encouraged to follow the care plan and if he declined, this should have been clearly recorded. Following the falls, there was no evidence of a care plan to reduce the risk of falling from the wheelchair – or evidence of Mr Brooker being encouraged to comply with directions to help to keep him safe. The only record of Mr Brooker declining to use the wheelchair seatbelt, was on the admission assessment (26.1.18). There was no evidence of encouragement after he began to fall from the wheelchair.

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 **13th May 2019**. 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] (son of Mr Brooker), to the CQC. I have also sent it to Matthew Cole, Director of Public Health 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	18/03/2019 Signature Miss N Persaud Senior Coroner **East London**