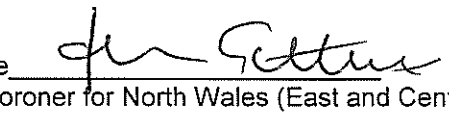
John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Manager, Emral House Nursing Home, 11 Chester Road, Wrexham LL11 2SH**
1	**CORONER** I am John Adrian Gittins, Senior Coroner for North Wales (East and Central)
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 3rd of May 2019 I commenced an investigation into the death of Edna Drury Evans (DOB 8.5.26 DOD 2.5.19) The investigation concluded at the end of the inquest on the 26th of September 2019 The conclusion of the inquest was one of an accidental death, the cause of death being 1(a) Subdural Haematoma (b)
4	**CIRCUMSTANCES OF THE DEATH** The deceased had become a resident at Emral House Nursing Home on the 24th of December 2018 following a number of falls. Whilst a resident there had been a number of further incidents relating to Mrs Evans between the 12th of March 2019 and the 27th of April 2019, all of which were documented as Accident Records. The final fall on the 27th of April was unwitnessed and resulted in a significant head injury which caused her death.
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. – The evidence provided at the inquest indicated that staff at the home were currently undergoing training in relation to the risk of falls but that this had not yet been fully completed. Furthermore, although the manager indicated in her evidence that a resident who had sustained a number of falls would be expected to be categorised as "high risk", she stated that Mrs Evans was only a "medium risk" despite the fact that she had had falls prior to admission and continued to have a number of falls whilst a resident.

Coroner's Office, County Hall, Wynnstay Road, Ruthin, LL15 1YN
Tel 01824 708047

	Although there was an assessment of Mrs Evans on the 11th of January (ie shortly after she became a resident) there is no evidence to suggest that there was any reassessment following further falls nor any apparent policy or protocol requiring this.
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 the 22nd of November 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 Family of the Deceased I am also under a duty to send the Chief Coroner a copy of your response and I shall also share your response with the above mentioned parties. 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 27th September 2019 Signature  Senior Coroner for North Wales (East and Central)