Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 [redacted], Registered Manager, Chilton Care Centre

1 CORONER

I am Jeremy Chipperfield, Senior Coroner of Durham and Darlington

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 Sixteenth May 2019 I commenced an investigation into the death of Robert Edward LOWE aged 95. The investigation concluded at the end of the inquest on twelfth September 2019. The conclusion of the inquest was:

I a Subdural Haemorrhage

I b

I c

II Dementia, Hypertension

4 CIRCUMSTANCES OF THE DEATH

Between 0159 and 0400hrs on 13th May 2019, the deceased suffered an unwitnessed fall to the floor of his bedroom at Chiltern Care Centre.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)

A) Circumstances at Chilton Care Centre are such that the placing of pressure mats (intended to detect residents leaving their beds unaided) is such that residents may bypass those mats;
B) The use and operation of audible signals is such that important audible alarms may not come to the attention of staff.

Mr LOWE left his bed and fell unwitnessed and then lay undetected by his bed for up to two hours until a scheduled welfare check. The pressure mat may not have been triggered. The basis for my concern is as follows:

(A) [redacted], Chilton Home Manager said that when she investigated this matter (by which time the mat had been removed) "*…there could have been a possibility that Mr LOWE, may have bypassed the mat when getting out at the top of his bed*…"(witness statement dated 11th August 2019); and

(B) In the same statement, [redacted] stated: "*Then… when staff carried out another welfare check, they found Mr Lowe on the floor. Three out of 4 staff on duty and only one believes that the mat*

had not activated and the other 3 could not remember if the sensor mat was making a sound or not, as the emergency buzzer was pressed and other buzzers around the home were also going at the same time, and their priority was Mr Lowe…"

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 07 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

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.

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Jeremy CHIPPERFIELD
Senior Coroner for
County Durham and Darlington
Dated: 20 September 2019