	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Director of Care and Operations Charing Healthcare**
1	**CORONER** I am Sonia Hayes Assistant Coroner for **Central and South East Kent**
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 22nd May 2019 an investigation was commenced into the death of Terence Ewart JAMES. The investigation concluded at the end of the inquest 11th December 2019. The conclusion of the inquest was Died on 14th May 2019 at William Harvey Hospital. He sustained a neck of femur fracture either on 17th or 20th April when he fell at his care home. The doctor was not informed prior to his visit on 17th April of the first fall on 17th. He was able to mobilise for a short period but fell again on 20th April at 10:25 and was unable to mobilise and deteriorated. An ambulance was called at 19:18, he underwent surgery but post-operatively became delirious and did not thrive. He was placed on end of life care. 1a **Bronchopneumonia** b c II **Frailty, Neck of femur Fracture (operated), Cerebrovascular disease**
4	**CIRCUMSTANCES OF THE DEATH** Mr James, 85, male was living in an EMI residential home (Chippendayle Lodge). He was admitted to William Harvey Hospital in the early hours of 21st April 2019 with a history of an un-witnessed fall on 17th April and a further fall on 20th April 2019 and pain in his hip and unable to weight bear since. X-ray confirmed that he sustained right neck of Femur fracture . He had right hemi-arthroplasty on the following day. Post operatively he became delirious; he did not thrive at all. His swallow deteriorated and oral intake was poor. He did not improve in spite of supportive management and was too unwell to transfer to a nursing home and died on the ward.
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 GP was due to attend Mr James on 17th April and was not informed of his fall prior to his attendance. He had bruising and abrasion to his head and was on anticoagulation medication. The GP examined him and found no apparent neurological symptoms or fracture. He advised that if there was any deterioration to seek further urgent advice. The GP evidence was that he would have advised that Mr James be taken to hospital. (2) The history of the fall on 17th April was not handed over to care staff who had returned from leave on 20th April. (3) A chiropodist raised concerns on 18th April that Mr James was in pain and this was not escalated for further medical advice. (4) Mr James sustained a further unwitnessed fall at approximately 10:25 on 20th April. This fall was not escalated for further medical advice until after a change of shift at 19:00 when his deterioration was immediately noted and escalated.

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 11th February 2020. 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] (Daughter on behalf of the family). 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	17th December 2019 Signature: S. M. Hayes Sonia Hayes Assistant Coroner **Central and South East Kent**