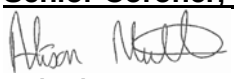
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The CQC and The Department of Health and Social Care
1	CORONER I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater Manchester South
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 23RD June 2020, I commenced an investigation into the death of Ruth Jones. The investigation concluded on the 19th January 2021 and the conclusion was one of Narrative: Died from natural causes contributed to by the recognised complications of an accidental fall. The medical cause of death was 1a) Bronchopneumonia II) Frailty, Dementia, Hypertension, Fractured Neck of Femur
4	CIRCUMSTANCES OF THE DEATH Ruth Jones resided at The Beeches Care Home. She was at risk of falls. On 17th June she showed signs of being unwell. Her GP remotely diagnosed suspected Covid 19 and she was isolated in her room with staff observations and use of sensor mats to reduce her risk of falls and ensure her wellbeing. She fell whilst unobserved. She was admitted to Tameside General Hospital, where a fractured neck of femur, bronchopneumonia and possibly Covid 19 were identified. Her Covid 19 test was negative. She was not fit for surgery and it was proposed she be discharged to the Care Home. On 20th June, she deteriorated and died at Tameside General Hospital from bronchopneumonia exacerbated by the fracture
5	<u>CORONER'S CONCERNS</u> 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 inquest heard that Mrs Jones was frail and at risk of falls. The home had a falls risk plan in place that was based around her being observed during the day in communal areas. The home was not staffed to provide one to one observations for residents required to self-isolate. As a result

	when Covid 19 was suspected by the GP, and the home were directed to isolate her she could not be observed by staff as would generally be the case in the day. The home took some steps with sensors to ensure they were aware if she stood up whilst in her room but could not provide continuous observation. It was unclear how homes were being advised to safely manage residents at risk of falls where isolation was required. The home were unaware of any guidance that they should follow to manage the risk. 2. When Mrs Jones had to go to hospital she was sent alone and her family could not go with her due to Covid 19 restrictions. The inquest heard that Mrs Jones was frail and vulnerable. The inquest was told that the unsupported presentation/assessment of vulnerable, frail and elderly patients such as Mrs Jones presented significant problems to clinicians in terms of effective communication and understanding their health baseline to support appropriate and timely clinical decision making.
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 8th April 2021. 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 namely [redacted], Ruth's Mother in Law and [redacted], Ruth's Grandaughter, 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	**Alison Mutch** **Senior Coroner, for the Coroner Area of Greater Manchester South**  **11/02/2021**