	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Director of Cole Valley Care Limited
1	**CORONER** I am Mr James Bennett HM Area Coroner for Birmingham and Solihull.
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 10 December 2020 I commenced an investigation into the death of Raymond Alfred POWELL. The investigation concluded at the end of the inquest.
4	**CIRCUMSTANCES OF THE DEATH** Raymond had become increasingly frail and fell in August 2020 fracturing his neck of humorous and went to live at Cole Valley Nursing Home on 28 September 2020. He was assessed as being at high risk of falling and his care plan and risk assessment identified practical measures to minimise his risk of falling, including half hourly observations and when mobilising it was agreed he would use a walking frame assisted by two carers. On 3 November at around 3.30am he shouted for help and was found on the floor in his bedroom and reported pain to his head. He was assessed by paramedics and remained at the nursing home. Around 10.30am carers responded to a sensor mat alarm and found him on the floor having apparently fallen out of a chair. He was admitted to the Queen Elizabeth Hospital where a CT scan revealed the fall(s) had caused a subdural haematoma which was treated conservatively. On 19 November he developed an infection and on 22 November suffered a seizure and it was confirmed the subdural bleed had worsened. He remained very poorly and passed away on 5 December 2020. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a Acute subdural haematoma; 1b Fall; and II Diabetes mellitus. The conclusion was Raymond's death was as a consequence of an accident.

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 nursing home manager confirmed that Cole Valley Nursing Home had not conducted an internal investigation into the circumstances of Raymond's death. The rational was "no foul play or inappropriate behaviour was suspected. Staff acted appropriately and phoned 999". I am concerned that it was not thought necessary to formally review the appropriateness of Raymond's falls risk assessment and the nursing home's policies and procedures to see what lessons could be learned to improve the safety of other residents. 2. The inquest did in fact reveal concerns around the nursing home's policies and procedures. (1) The nursing home manager confirmed that a preceding fall (most likely on 15 October) had not been recorded anywhere within Raymond's file and this was the first time she was aware of a preceding fall (Raymond's family's evidence was they were told during a visit on 15 October, and nursing home carer [redacted] confirmed there was a preceding fall a few weeks earlier). The nursing home manager was unable to explain why this preceding fall had not been recorded anywhere. (2) The nursing home manager in her written report to the Coroner stated that Raymond's falls risk assessment had been updated. However, the evidence revealed in fact the falls risk assessment had been created on 30 September upon Raymond's arrival, and had never been updated. Raymond's named nurse should have reviewed and updated it at the end of October with the preceding fall on 15 October being a key factor in the updated assessment. The nursing home manager was unable to explain why the named nurse did not update the falls risk assessment as expected. (3) On 3 November staff were observing Raymond every 15 minutes however they only endorsed the 30 minute boxes on his observation log meaning it was misleading. 3. The nursing home failed to comply with repeated court orders to supply relevant evidence. On 14 December the nursing home manager was ordered to supply evidence by 18 January. With no response the court order was extended on 8 February to 10 February. One day late, on 11 February, the nursing home manager supplied the witness statements but no documents. On 16 February the nursing home manager was ordered to supply the documents by 23 February. With no response the nursing home manager was served with a schedule 5 notice containing a penal notice to supply the documents by 18 March. In breach of the schedule 5 notice, on 22 March the nursing home manager supplied some but not all documents. I did not accept the reported problem with an email account as justifying the repeated failure to comply with court orders for 3 months. In summary, I am concerned that the nursing home has not sought to learn the lessons from the circumstances of Raymond's death and as a consequence there is an ongoing risk to other residents.
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 24 May 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: the family of Raymond Powell. I have also sent it to the Care Quality Commission 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	**29 March 2021**  Signature: **James Bennett** **HM Area Coroner for Birmingham and Solihull**