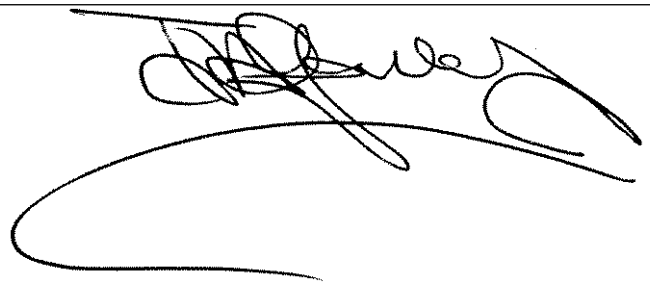
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted](Son)** **2. Anchor Hanover Group – Widnes Hall Care Home, Widnes Lodge, Coronation Drive, Widnes, Cheshire** **3. Director with responsibility for Care Homes Care Quality Commission – Care Quality Commission (North West) Citygate Gallowgate Newcastle-Upon-Tyne** **4. HM Chief Coroner HH Judge T Teague**
1	**CORONER** I am Julie Goulding, Senior CoronerSenior Coroner, for the coroner area of Sefton, St. Helens and Knowsley
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 20 April 2020 I commenced an investigation into the death of Pauline BRUMFITT, 91. The investigation concluded at the end of the inquest on 25 March 2021. The conclusion of the inquest was I a Intracranial bleed I b I c II Secondary to Fall
4	**CIRCUMSTANCES OF THE DEATH** Pauline BRUMFITT sadly died on 15th April 2020 at John Joseph Powel Nursing Home Merseyside. Pauline had been cared for in another care home where she had an unwitnessed fall on 29th February 2020. Pauline was found on the floor having fallen at about 15.25 hrs. The family who had visited earlier report leaving at about 14.45. Pauline was taken to hospital where she was diagnosed with an intracranial bleed. Upon her discharge from hospital Pauline went to a different nursing home, which is where she sadly passed away as stated. The Care Home where Pauline fell did not undertake a falls risk assessment for Pauline as they should have done. There was no falls mat or falls alarm in situ at the care home at the time of her third and final fall or at all.

	There was no falls prevention plan put in place as there should have been and there was no referral for advice from the falls team at the Local Authority. Pauline had suffered from two previous falls at the same Nursing Home and the fall (3rd), leading to the admission to hospital (and the subsequent diagnosis of an intracranial bleed) caused or contributed to the death of Pauline Brumfitt.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The policies and procedures in existence at the care home pertaining to falls risk assessment and prevention were not applied to Pauline Brumfitt (as stated above) as they should have been. (2) Pauline fell on 3 occasions and the opportunities to assess Pauline's risks and take appropriate action to prevent further falls were not taken as they should have been. (3) The matter was (given in evidence) not reported to the regulatory bodies and again as given in evidence an investigation had not been commenced at the time of the inquest and staff supervision/discussion re falls prevention had only been commenced in Feb/March 2021, appropriate timely action could have helped (and could still help) to prevent future deaths in similar circumstances where dependent elderly residents are at risk of falling and suffering serious injury/death as a consequence.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 01 June 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 [redacted] and the Care Quality Commission. 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	



Julie GOULDING
Senior Coroner for
Sefton, St. Helens and Knowsley
Dated: 06 April 2021