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. The Manager, Shannon Court Care Centre;** **2. Chief Officer, NHS Bolton CCG;** **3. Chief Officer, Commissioning Services, Bolton Council;**
1	**CORONER** I am Timothy William Brennand, HM Senior Coroner, for the coroner area of Manchester West.
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 13th November 2020 I commenced an investigation into the death of KENNETH SMITH, aged 83. The investigation concluded at the end of the inquest on 20th May 2021. The conclusion of the inquest was a short conclusion of 'Accident'. The medical cause of death was: 1a) Acute on chronic subdural haematoma 1b) Fall
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a medical history that included known cognitive impairment and presumed Vascular Dementia, throat cancer and a previous subdural haematoma following an accidental fall. From the 8th of October 2020 his care needs were being met at the Shannon Court Care Home in Bolton. He had been assessed as presenting as a high risk of falls, requiring constant day and night supervision by a care worker. On the 22nd of October 2020, the level of supervision was reduced to night-time supervision between 7pm and 7am. This was a decision made by the care home staff in consultation and agreement with NHS Bolton Clinical Commissioning Group and the local authority. At lunchtime on the 31st of October 2020, whilst suddenly attempting to self-mobilize from a chair in the dining hall, the deceased suffered a witnessed fall from standing, face first to the floor. He was admitted to the Salford Royal Hospital, Stott Lane, Salford and diagnosed with a chronic subdural haematoma with compression on the left hemisphere and acetabular fracture. He was not a candidate for surgical intervention and so after assessment was treated conservatively. He progressively deteriorated - to the extent that by the 3rd of November it was recognised that his condition was un-survivable, receiving palliative care until his death on the 9th of November 2020.

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. – After a purported re-assessment of the falls risk posed by the deceased on the 22nd of October 2020 following his 14-day period of self-isolation in his room the evidence established that the deceased was to suffer 6 falls between the 22nd and 29th of October 2020. Two of these falls took place on the 22nd of October 2020 – the same date of the reduction in the level of care being offered. The evidence from the care home manager indicated that there was no date that had been given for a future review. It was also accepted that there was no action taken to consider a further falls risk assessment after any of the falls recorded in the Accident Record including no action taken on the 29th of October 2020 when the deceased suffered two falls, resulting in skin tears and a head injury. Additionally, the evidence established that on release from hospital to the care home on the 8th of October 2020, the discharge clinicians had stopped the prescription of Trazadone to the deceased because it was too sedating. There was no evidence that the change in medication regime had been taken into account by carers adequately, or at all (as part of the falls risk assessment). Care staff had only escalated concerns over the deceased's progressive agitation to a general practitioner on the 30th of October 2020. This had resulted in a referral to the Older Person's Mental Health Team. There was no evidence as to why further advice from a mental health practitioner was not sought earlier, or as part of the risk assessment on the 22nd of October 2020. The nature and quality of the care received by the deceased between the 22nd and 31st of October 2020 reveal the following concerns: 1. The decision to reduce the level of supervision was suboptimal, incorrect and flawed; 2. The failure to consider and specify a review date; 3. A lack of escalation process in the event of problems or issues with the reduced care plan that might prompt an urgent review; 4. The events of the 31st of October 2020 had not triggered any serious or untoward incident review by the care home, the CCG, or local authority;
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 Monday 19th July 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] Next of Kin; [redacted] Chief Executive for the Care Quality omission; and [redacted] at Bradford Street Surgery. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.	
9	**Date** **Monday 24th May 2021**	**Signed** **Timothy W Brennand, HM Senior Coroner for Manchester West**