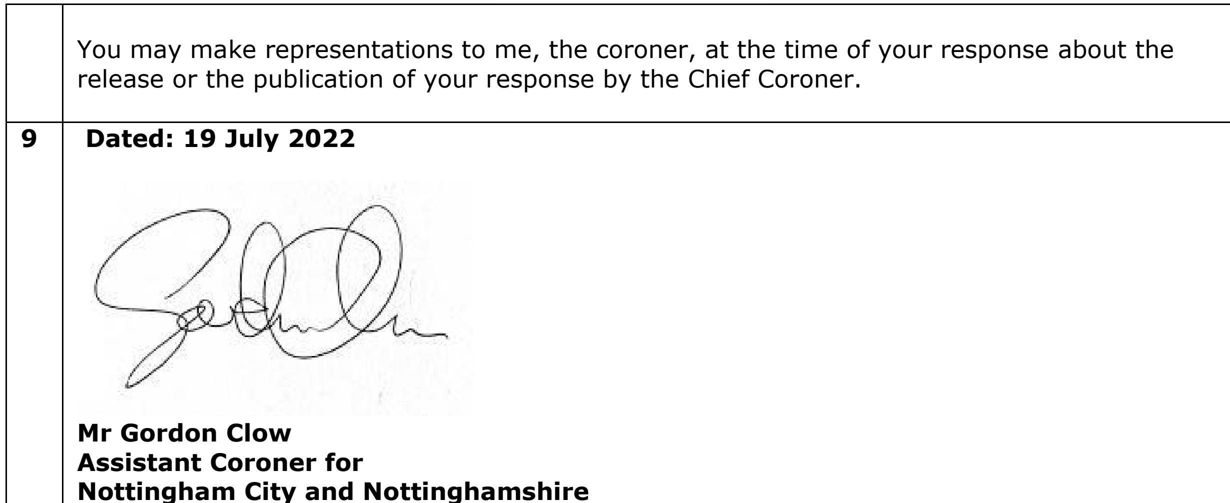
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Radcliffe Manor House Care Home**
1	**CORONER** I am Mr G. Clow, Assistant Coroner for the coroner area of Nottingham City and Nottinghamshire
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 2 August 2021 I commenced an investigation into the death of Beryl Simcock, aged 90. The investigation concluded at the end of the inquest on 22 June 2022. The conclusion of the inquest was that Beryl Simcock died by accident.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Simcock lived in a care home due to her care needs arising from her dementia. Her condition deteriorated during the year leading up to her death following two bouts of Covid-19. Mrs Simcock suffered a number of falls within the bedroom of her care home. In the period leading up to her death she fell twice in March 2021 and then fell again on 10 June 2021. This last fall resulted in an impacted fractured neck of femur. This fall severely affected Mrs Simcock's health and she was admitted to hospital. The fall occasioned a significant deterioration in her dementia and resulted in her spending most of her time in bed. She received treatment for medical problems arising from the fall but did not improve. She was then discharged on end of life care and died in a nursing home two days later. Mrs Simcock's care plans were not changed in light of her changing care needs. No proper falls risk assessments were undertaken within the care home. It is not possible to say whether or not falls measures could have been implemented which would have avoided the fall which led to Mrs Simcock's death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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)

	I was concerned about the lack of written policies for care planning and review. I was concerned that reviews of care plans and risk assessments were either not done (and the records falsified to suggest that they were) or that they were done by someone unsuited to the task. This was not identified despite audit activity during the relevant period. I was also concerned that at times when Mrs Simcock was deprived of her liberty the care home did not ensure that her family were given adequate and timely information to enable them to provide independent scrutiny of the care and restrictions in place. It is requested that consideration be given to:- 1. Taking steps to ensure that family members are informed of falls and other significant incidents experienced by residents, particularly where the resident concerned lacks capacity and / or is deprived of their liberty; and 2. Taking steps to ensure that risk assessments and care plans are regularly reviewed competently and that the records truly reflect what risk assessments and care plans have taken place.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 14 September 2022. 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 Beryl Simcock** **Nottingham University Hospitals NHS Trust** **St George's Medical Practice** **Nottinghamshire County Council** 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 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 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 by the Chief Coroner.
9	**Dated: 19 July 2022**  **Mr Gordon Clow** **Assistant Coroner for** **Nottingham City and Nottinghamshire**