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:** Residential Manager, Elm Tree Court Care Home, 344, Preston Road, Hull, HU9 5HH And their overseeing management: HICA Group, Anchor Court, Francis Street, Freetown Way, Hull, HU2 8DT.
1	**CORONER** Lorraine Harris, Area Coroner, East Riding of Yorkshire and City of Kingston Upon Hull.
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 25th April 2022 I commenced an investigation into the death of Robert Norman HOWELL, age 91 years. The investigation concluded at the end of the inquest on 23rd September 2022. The conclusion of the inquest was: Narrative: Robert Norman Howell "Bob", aged 91 years, was susceptible to falling. On 12th April 2022 in his room at Elm Tree Court care home Mr Howell fell backwards and banged his head sustaining a subdural haematoma. He was conveyed to Hull Royal Infirmary where he died on 20th April 2022. Cause of Death: 1a Subdural Haematoma 2 Atrial Fibrillation, Severe left ventricular systolic dysfunction and Aortic Stenosis
4	**CIRCUMSTANCES OF THE DEATH** Mr Howell have a history of falls and did not have capacity. In February 2022 he went to reside at Elm Tree Court care home. He had the relevant pre-assessment before admissions and had care plans devised when in the home. He suffered falls on 10th and 11th April 2022. Care staff for the night of 11-12th April 2022 were made aware of the fact he had fallen once on 11th, but not his

	history of frequent falls. In the early hours of the 12th April 2022 his sensor mat activated, indicating that he had got out of bed. The carer attended and found him standing by his bed, he was naked. The carer was unsure why she did not firstly ask him to sit on the bed but she spoke to him and moved to his wardrobe to obtain clothing for him. As she did so he stumbled backwards and struck his head. An ambulance was called. He died in hospital from a subdural haematoma on 20th April 2022.
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. – (1) Team Leaders held handovers between themselves, it was then up to the individual Team Leader to decide what to pass on to the staff responsible for caring. It became apparent during evidence that often vital caring and risk needs were not always cascaded to the staff interacting with the residents. As such vital information to those responsible for providing care was often not provided. (2) Care plans were held in the office. Staff were not instructed to read the care plans. It was left to an individual carer to decide if they wished to seek out the care plan. No time was set aside for staff to familiarise themselves with the care plan or individual needs and risks of the residents. Vital information could therefore be missed by those responsible for providing care. (3) Evidence showed a lack of understanding about the falls policies in place. (4) It was acknowledged that the home did have procedures introduced since Mr Howell's death however it became evident that there was still a breakdown in communication and vital information was not being shared. There appeared to be a lacuna in what information should be passed to all staff and how confirmation of understanding was checked.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 16th November 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: • [redacted] (sister) as a representative of the family 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]** **[SIGNED BY CORONER]** ***26th September 2022*** ***Lorraine Harris***