REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Lean on Me care agency**
1	**CORONER** I am Lydia Brown, Acting senior coroner, for the coroner area of West London
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 22 July 2021 I commenced an investigation into the death of Gunapathyammah Ranganathan . The investigation concluded at the end of the inquest on 15 February 2023. The conclusion of the inquest was Medical cause of death - 1a Traumatic Intracerebral Haemorrhage and skull fracture 1b Fall II Frailty, Type 2 Diabetes Mellitus, Hypertension, Rheumatoid Arthritis Mrs Ranganathan was elderly and frail and required the assistance of one carer to mobilise. On 11th July she was attended by a new, inexperienced carer who had insufficient training and shadowing to enable her to support Mrs Ranganathan safely during the morning care visit. While walking with her zimmer frame to the bathroom she was unattended and lost her balance, fell backwards and hit her head. She sustained a severe head injury that was unsurvivable and she died in St Mary's Hospital on 14 July 2021. Had she been assisted in an appropriate way, it is probable that the fall could have been avoided. Conclusion Accidental Death
4	**CIRCUMSTANCES OF THE DEATH** See above

A st	**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. – There was little evidence before the court that the new carer had received any or any adequate training or shadowing experience. The new carer could not be deemed to be competent at mobilising a service user with a zimmer frame as there was no evidence that she had done so. Lean on Me care agency was said to not currently be trading, but the company and web site remain live and therefore could recommence work in the care sector. The court requires confirmation of training schedules and policies, together with shadowing policies for new carers with no previous experience or training and confirmation that steps have been taken to avoid the situation that arose in this case, when a service user who should have been under direct supervision at all times when mobilising was unattended, and sustained a fatal head injury when she fell.
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 8th May 2023. 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 Gunapathyammah Ranganathan [redacted] I may also send a copy of your response to any other person who I believe may find it useful or of interest, and will therefore send a copy to CQC London Borough of Ealing 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	**13th March 2023** **HM acting senior coroner Lydia Brown**