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:** **1 Silver Birches Care Home**
1	**CORONER** I am Professor C E MASON, His Majesty's Senior Coroner for the coroner area of Leicester City and South Leicestershire
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 31 March 2022 I commenced an investigation into the death of Janet SMITH aged 81. The investigation concluded at the end of the inquest on 24 April 2023. The conclusion of the inquest was Accidental death with a medical cause of death being given as: 1 a) Pneumonia 1 b) Multiple Spinal Vertebral Fractures 1 c) Fall 2) Advanced Dementia, Frailty, Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** Janet Smith was an 81-year-old woman with a history of advanced dementia and ischaemic heart disease, who was found by carers on the floor following an unwitnessed fall in an unsafe environment at around 20.00 hours on 15 March 2022, at the Silver Birches care home, Leicester, where she was a resident. Although Mrs. Smith sustained no obvious physical injury, she complained of head pain the same evening and was taken by ambulance to the Leicester Royal Infirmary in the early hours of 16 March 2022, where she was diagnosed with spinal fractures. On a balance of probabilities, the injuries were caused by a high energy fall and in keeping with having fallen down the stairs. At the hospital Mrs. Smith was treated conservatively due to her age and dementia; she deteriorated over the following days and, after discussions with family members on 21 March 2022, she was placed on palliative care and died the following day.
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) At the time of Mrs. Smith's fall, there were 17 residents and 2 carers. One carer was attending a resident upstairs and the other carer was outside the care home accompanying another resident who wished to have a cigarette. This meant that no carer was in the lounge area monitoring the residents. Accordingly, when Mrs. Smith left the lounge area she was not monitored as required. If she had been monitored, it is understood that she would have been offered assistance and, on a balance of probabilities, the fall that led to her death would not have occurred. It was understood that at the care home there were, and still is, a number of residents with challenging behaviour and care needs, and that for some activities of daily living 2 carers may be required. With only 2 carers on a shift, it is foreseeable that residents can and will be left unattended. It is also foreseeable that competing needs of the residents will mean that residents will be left unmonitored, and an unsafe environment created as occurred with Mrs. Smith. Accordingly, there remains a concern that the provider has not done everything possible to mitigate the risk of actual or potential harm including death.
6	**ACTION SHOULD BE TAKEN** In my opinion 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 June 21, 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: [redacted] [redacted] [redacted] **Care Quality Commission** 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: 26/04/2023**  **Professor C E MASON** **His Majesty's Senior Coroner for Leicester City and South Leicestershire**