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 [redacted], Care UK, Connaught House, 850 The Crescent, Colchester Business Park, Colchester, Essex C04 9QB**
1	**CORONER** I am HEIDI J CONNOR, Senior Coroner for Berkshire for the coroner area of Berkshire
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** I conducted an inquest into the death of Jennifer Evelyn RACKLEY, aged 81 years. The investigation concluded at the end of the inquest on 17 May 2023. The family asked me to refer to Mrs Rackley as Jennifer during the inquest, and I have respected that request in this report. Jennifer died at Wexham Park Hospital on 15th January 2022 after a fall in her nursing home on 17th December 2021. Her cause of death was: 1 a Multi-organ Failure 1 b Sepsis from infected Hip 1 c Fractured Neck of Femur (Operated) 2 Atrial Fibrillation, Frailty, Dementia, Hypertension, Colorectal cancer, Covid 19 Infection The conclusion of the inquest was that Jennifer Evelyn Rackley died as a result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Jennifer was born on the 22nd of June 1940. She had an extensive past medical history, including cancer, dementia, atrial fibrillation, and previous DVT. She suffered a fall at Queen's Court Nursing Home in Windsor on the 17th December 2021. Evidence was given under oath by the manager of the care home. Her evidence was that: 1. Staff were alerted to Jennifer's fall by the sensor mat sounding. 2. Jennifer's bed was against the wall and therefore only required 1 sensor mat. 3. The home had carried out an investigation into the circumstances of the fall. It was clear from the evidence that staff were alerted to Jennifer's plight by her shouting and not by a sensor mat sounding. In documents provided for the first time in court, it was clear that the first trigger of the sensor mat was at 0632 on the 17th of December, some 7 minutes after the computer generated record of the fall in Jennifer's notes (with the time automatically generated). Jennifer was already on the floor at that time. It is likely that the sensor mat was triggered by somebody else in the room who went to assist her and not by Jennifer herself.

	I was concerned about evidence given under oath that the bed was against the wall with the need only for one sensor mat. The evidence from two separate family members was very different on this point. They both said that the bed was in the centre of the room with a sensor mat on one side only. Their evidence was consistent and convincing. The manager, despite earlier giving clear evidence about the bed position, then accepted that she could not remember this, and she had assumed the bed was against the wall. I was told that the care home had conducted an investigation after Jennifer's fall and subsequent death. I was told that there is no report / written record of this. The care home manager who attended the inquest (with the benefit of legal representation), could not even tell me the names of the carers who were involved on the 17th of December. She accepted in her evidence that she assumed the bed was against the wall because that was usual. She did not have a specific memory of this. She also later accepted that it is likely that the sensor mat was triggered by someone else in the room after the fall, and not by Jennifer herself. It is fair to note that these events were some time ago, and that memories fade. But it is an entirely different matter to give positive evidence rather than simply saying that one cannot remember something.
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) (1) It seems likely that Jennifer's bed was in the centre of the room, with one sensor mat only, despite a high falls risk. (2) Evidence was given that an investigation was carried out – despite no written document / record of this being made - and the manager being unable even to name the care staff involved in the incident.
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 August 01, 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 **Family** **Legal representative of Wexham Park Hospital** 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: 06/06/2023**  **HEIDI J CONNOR** **Senior Coroner for Berkshire for Berkshire**