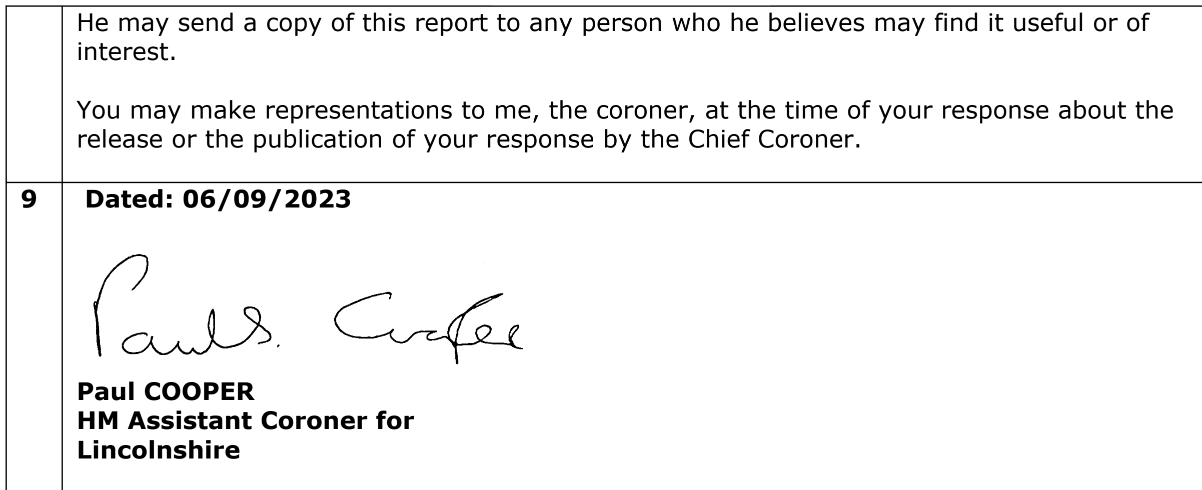
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Phoenix Care Centre**
1	**CORONER** I am Paul COOPER, HM Assistant Coroner for the coroner area of Lincolnshire
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 19 February 2021 I commenced an investigation into the death of Sheila Rosamund JOHNSON aged 91. The investigation concluded at the end of the inquest on 15 November 2022. The conclusion of the inquest was that: The deceased died on 14th February 2021 at Butterfly Hospice, Rowan Way, Boston after being transferred there from hospital following an unwitnessed fall at her care home resulting in fatal injuries.
4	**CIRCUMSTANCES OF THE DEATH** Reported to the coroner by [REDACTED] (Staff Nurse Butterfly Hospice) - Daughter wishing for the coroner to be involved as she believes her mothers death was the consequence of a fall at the care facility. Following fall admitted to Pilgrim Hospital transferred to Hospice. Expected death at the hospice, was admitted on 11-02-2021 I have spoken to the coroners officer [REDACTED]. on 14022021 Contacted Sidings Medical Centre for patient history. Contacted NOK (daughter [REDACTED] - via husband [REDACTED]) who explained that the deceased had been living in Phoenix Care Home for about a year and is believed to have suffered a fall there on 03/02/2021 where she was transferred to PHB with suspected multiple rib fractures and a punctured lung. Due to her age there was nothing other than palliative care and she was subsequently transferred from PHB to Butterfly Hospice where she died on 14/02/2021. PM examination carried out by [REDACTED] 17/02/2021 Contacted [REDACTED] (manager - Phoenix Care Centre) who explained the fall occurred on 03/02/2021 at approx. 20.22hrs. She explained that Sheila suffered from advanced dementia and liked to 'walk with a purpose' and was allowed to wander around the building, she was not described as a frail lady with more of a substantial frame to her. [REDACTED] believes she was on two types of medication used for patients with bone issues to build their bone density but can't remember the names of the medication On the evening of the fall she had gone into a neighbours bedroom while the resident was elsewhere in the building, the room was dark at the time and staff herd her cry out. On entering the room they found her flat on her back on the floor but on top of the beds duvet

	that had been pulled off the bed. The bed in this room was described as a 'Profiling Bed' they are designed with a taller base board and also have a metal bar above the base board, [REDACTED] thought it was possible for her to have fallen onto the base of the bed. On arrival there were no obvious signs of injury to Sheila however she was clearly in pain so the team called 999 for assistance before moving her from the floor. On the arrival of paramedics she was raised to a chair by the paramedics and still in obvious pain so conveyed to Pilgrim Hospital. PM examination carried out by [REDACTED] who confirmed cause of death related to multiple rib fractures.
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.An inadequate generic falls prevention policy appeared to be in place. 2.Doors to unoccupied rooms were unlocked when they should have been locked. 3.Night light in common places not on. 4.No signage to bell ring in place. 5.Indequate periodic nightly observations recorded at inquest. What adjustments have been made to practice and procedure?
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 November 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 **Phoenix Care Centre** I have also sent it to [REDACTED] 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: 06/09/2023**  **Paul COOPER** **HM Assistant Coroner for Lincolnshire**