ANNEX A

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:

- Home Manager, Broomcroft House Nursing Home, 414 Ecclesall Road South, Sheffield, S11 9PY
- 2. General Manager, UK Care Services, Bupa Care Homes,

1 CORONER

I am Marilyn Whittle, assistant coroner, for the coroner area of South Yorkshire (West)

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 9 June 2023 I commenced an investigation into the death of Norma Kyte, 87 years old. The investigation concluded at the end of the inquest on 6 October 2023. The conclusion of the inquest was death by natural causes. The medical cause of death was 1a alzheimer's disease, age related frailty 2 fall.

CIRCUMSTANCES OF THE DEATH

Norma Kyte died on 4 June 2023 at Broomcroft House. On 2 May 2023 she had an unwitnessed fall at the nursing home. This fall did not trigger the sensor mat which had been placed on the floor and therefore was not identified by staff until she was checked upon. The mat used on the floor had been deemed appropriate to be used in this way by the nursing home, but did not cover all the area by the bedside and would not trigger unless it was directly stood upon. The care home were unable to identify if this was used in accordance with manufacturers instructions.

Norma was taken to Northern General Hospital for an x-ray and diagnosed with a right supracondylar femoral fracture. She was discharged with a full length cast on her leg.

Following this she was seen on numerous occasions by the GP for vacant episodes, agitation and reduced oral intake. Treatment was given but she continued to deteriorate. The Care Home Manger confirmed that when Norma returned to the home she had completely changed in presentation and that this had had a big impact upon her. She was last see on 2 June by the GP where she had further reduced responsiveness and oral intake. She continued to decline and passed away on 4 June 2023.

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) The sensory mats being used on the floor next to the bedside are significantly smaller than the bed and will only trigger when directly stood upon. If a patient gets out of bed in a place not covered by the mat this will not be trigger a response from the care home staff and they will be unaware the patient is trying to move or has fallen. (2) The sensory mats may not be being used in accordance with manufacturers instructions. **ACTION SHOULD BE TAKEN** 6 In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 5 December 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 Hilary Sayer the daughter of Norma Kyte. I am also under a duty to send the Chief Coroner a copy of your response. 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 Muhettle 12/10/2023 **Marilyn Whittle**