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:** [redacted] **(manager) - Abbey Wood Lodge Care home**
1	**CORONER** I am Julie GOULDING, Senior Coroner for the coroner area of Sefton, St. Helens and Knowsley
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 28 April 2023 I commenced an investigation into the death of Julia MURPHY aged 89. The investigation concluded at the end of the inquest on 29 November 2023. The conclusion of the inquest was that: Julia Murphy (known as Sheila) sadly died on 09/04/2023 at Southport Hospital Merseyside PR8 6PN. Julia was 89 years of age at the time if her death. On 06/04/2023 Julia suffered a fall in the care home where she resided, she was admitted to hospital, however, she was too unwell for surgery to the fracture she had sustained when she fell. Notwithstanding all appropriate care and treatment in hospital Julia's condition deteriorated culminating in her death. From the time Julia was resident in the care home she suffered 21 falls, the first being on 15/01/2022 and the last being on 06/04/2023. The final fall when Julia sustained a fracture to her hip caused her death. During her stay in the care home only 3 referrals were made for advice from the specialist falls prevention team, the first on 30/09/2022, the second on 24/11/2022 the day after her 13th fall on 23/11/2023, it is worthy of note, there was no response from the falls prevention referral on the first occasion and a second referral was not made until Julia had fallen again. A physiotherapist assessed Julia on 10/01/2023 and recommended the use of a zimmer frame, on 19/01/2023 the falls prevention team recommend Julia should use a zimmer frame, a falls sensor mat, a crash mat and they also recommended Julia should be encouraged to come out of her room during the day. A crash mat was deemed inappropriate. The third referral to the falls team was made on 10/03/2023, this referral stated ……. "Sheila has had 18 falls since 01/01/2022". Julia had suffered four falls over the 5th & 6th March 2023. The first referral form (reason for referral box, on page 1) stated "struggling to walk even short distances and is holding to everything when walking. It might be better with a Zimmer frame or something similar to that". There was no mention in the reason for referral box of Julia's falls history even though at the time she had fallen 12 times when that fall occurred.

	The referral form dated 24/11/2022, (reason for referral box) stated "had a few falls since January this year, sensor mat is in place and OT referral was sent on 30/09/22 and that has been chased up today 24/11/2022". By the 24/11/2022 Julia had fallen 13 times. The first referral, in the reasons for referral box did not describe the fact that Julia had suffered 12 falls, as it should have done, and it was not followed up as it should have been until the day after she had fallen on 23/11/2022. The referral on 23/11/2022 stated in the reason for referral box, Julia had a few falls since January this year when in fact at that time she had fallen in the care home 13 times. Julia was subsequently assessed, and some falls prevention measures were put in place. However, funding was not formally sought for 1-1 supervision as it should have been, the fact that Julia had suffered so many falls was not escalated as it should have been and the final fall i.e. the 21st fall that Julia suffered on 06/04/2023 tragically caused her death.
4	**CIRCUMSTANCES OF THE DEATH** Julia Murphy (known as Sheila) sadly died on 09/04/2023 at Southport Hospital Merseyside PR8 6PN. Julia was 89 years of age at the time if her death. On 06/04/2023 Julia suffered a fall in the care home where she resided, she was admitted to hospital, however, she was too unwell for surgery to the fracture she had sustained when she fell. Notwithstanding all appropriate care and treatment in hospital Julia's condition deteriorated culminating in her death. From the time Julia was resident in the care home she suffered 21 falls, the first being on 15/01/2022 and the last being on 06/04/2023. The final fall when Julia sustained a fracture to her hip caused her death. During her stay in the care home only 3 referrals were made for advice from the specialist falls prevention team, the first on 30/09/2022, the second on 24/11/2022 the day after her 13th fall on 23/11/2023, it is worthy of note, there was no response from the falls prevention referral on the first occasion and a second referral was not made until Julia had fallen again. A physiotherapist assessed Julia on 10/01/2023 and recommended the use of a zimmer frame, on 19/01/2023 the falls prevention team recommend Julia should use a zimmer frame, a falls sensor mat, a crash mat and they also recommended Julia should be encouraged to come out of her room during the day. A crash mat was deemed inappropriate. The third referral to the falls team was made on 10/03/2023, this referral stated ……. "Sheila has had 18 falls since 01/01/2022". Julia had suffered four falls over the 5th & 6th March 2023. The first referral form (reason for referral box, on page 1) stated "struggling to walk even short distances and is holding to everything when walking. It might be better with a Zimmer frame or something similar to that". There was no mention in the reason for referral box of Julia's falls history even though at the time she had fallen 12 times when that fall occurred. The referral form dated 24/11/2022, (reason for referral box) stated "had a few falls since January this year, sensor mat is in place and OT referral was sent on 30/09/22 and that has been chased up today 24/11/2022". By the 24/11/2022 Julia had fallen 13 times. The first referral, in the reasons for referral box did not describe the fact that Julia had suffered 12 falls, as it should have done, and it was not followed up as it should have been until the day after she had fallen on 23/11/2022.

	The referral on 23/11/2022 stated in the reason for referral box, Julia had a few falls since January this year when in fact at that time she had fallen in the care home 13 times. Julia was subsequently assessed, and some falls prevention measures were put in place. However, funding was not formally sought for 1-1 supervision as it should have been, the fact that Julia had suffered so many falls was not escalated as it should have been and the final fall i.e. the 21st fall that Julia suffered on 06/04/2023 tragically caused her death.
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) Julia had 21 falls, the final fall led to her death. The 3 referral forms sent to falls prevention were incomplete, misleading and/or inaccurate. An action plan in respect of preventing future deaths from falls/falls prevention/the learning following these events was not presented at Inquest nor did there appear to be a clear plan to address inter alia; 1. Accurate/timely reporting of falls/accurate timely, completion of referral forms to the falls prevention team . 2. Escalation when such a significant number of falls were sustained by 1 frail, elderly person. 3. Meeting the needs of the resident with evolving dementia, particularly in respect of mobility, supervision, falls prevention and risk assessment. 4. Formally requesting 1-1 supervision funding when necessary/as appropriate on a case by case basis. 5. Training/development/organisational learning following these events re falls prevention and accurate reporting/escalation. The above list is not exhaustive and the care home management/owners will be best placed to develop their own action plan following the death of Julia.
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 January 25, 2024. 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] **- NOK** I have also sent it to **CQC**

	[redacted]**-Business Unit Head for Urgent Care and Community Services - HCRG Care Group** [redacted] **– Executive Director of Adult services and Health & well Being – Lancashire County Council** 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: 30/11/2023**  **Julie GOULDING** **Senior Coroner for** **Sefton, St. Helens and Knowsley**