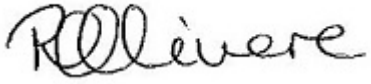
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Birmingham City Council,** **2. Connaught House Care Home**
1	**CORONER** I am Rebecca Ollivere, Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 24 April 2023, I commenced an investigation into the death of Sylvia May NASH. The investigation concluded at the end of the inquest on 25th September 2023 . The conclusion of the inquest was; Accident
4	**CIRCUMSTANCES OF THE DEATH** **On 11th March 2023, the deceased fell at The Orchards Nursing Home where she resided. She was taken to Birmingham Heartlands Hospital where she underwent surgical fixation of a fractured neck of femur sustained in that fall. Post operatively, she developed septic shock, and despite treatment, continued to deteriorate. She died in hospital on 14th April 2023.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Sepsis** **1b Prosthetic joint infection** **1c** **II Fractured neck of femur operated, Lewy Body Dementia**
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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. It was clear both from the evidence and subsequent correspondence that the correct process for making decisions, such as (but not exclusively), removal of 1:1 observations, is not understood adequately by all parties who should be involved in that decision making process. 2. Whilst the Council understood this to be a multi-disciplinary process involving any professional involved in the patient's care, the care home, Connaught House, indicated that this decision rests solely with the Council.

	3. This is concerning for two reasons. Firstly, the correct procedure is not understood and therefore has not been followed. Secondly, the fact that the care home, where the patient resides is of the view that they are not responsible for making decisions as to removal of observations ahead of transfer. They, in my view, should be pivotal in this decision as the organisation who have had the most contact with the patient and therefore in a position to provide important information as to risk and behaviour. 4. I am concerned that the communication and understanding of the correct process between agencies is insufficient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 27 February 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] – Daughter of Mrs Sylvia Nash Care Quality Commission 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	**2 January 2024** Signature:  **Rebecca Ollivere** **Assistant Coroner for Birmingham and Solihull**