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 Stanley Park Care Centre**
1	**CORONER** I am Janine RICHARDS, Assistant Coroner for the coroner area of County Durham and Darlington
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 21/09/2023 11:12an investigation was commenced into the death of Margaret AUSTIN 13/03/1933 00:00:00. The investigation concluded at the end of the inquest on 27/11/2023 00:00. The conclusion of the inquest was that Margaret Austin, who was 90 years of age and had a diagnosis of mixed dementia, died on the 17th of September 2023 at her care home. The deceased had sustained a pubic rami fracture in an unwitnessed accidental fall from her bed, at her care home, on the 1st of July 2023, and this contributed to her overall decline and ultimately to her death..
4	**CIRCUMSTANCES OF THE DEATH** Mrs Austin passed away at Stanley Park Care Home. She had recently suffered a fractured pubic rami due to an unwitnessed fall.
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. The deceased was known to be at high risk of falls and the documentation in relation to how to manage that known high risk of falls was not comprehensive and contained significant discrepencies as to what should, in fact, be in place, and contained no rationale for why further measures which may have been considered appropriate were not in situ or considered appropriate or necessary. 2. There was no evidence that the risk management plan was reviewed as the deceased's risks changed nor in the aftermath of documented falls. 3. Staff training in relation to falls risk remained outstanding at the date of the Inquest for the majority (3/4) of staff at the care home.
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 22, 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] I have also sent it to 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: 27/11/2023** **Janine RICHARDS** **Assistant Coroner for** **County Durham and Darlington**