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:** **The Limes Care Home** **16A Drayton Wood Road** **Hellesdon** **Norwich** **Norfolk** **NR6 5BY**
1	**CORONER** I am Jacqueline LAKE, HM Senior Coroner for the coroner area of Norfolk
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 29 September 2021 I commenced an investigation into the death of Edith Jane ALDEN aged 89. The investigation concluded at the end of the inquest on 10 April 2024. **The medical cause of death was:** 1a) Traumatic Subdural and Subarachnoid Haemorrhage with intraventricular extension 1b) Fall 1c) 2) Frailty, Type 2 Diabetes Mellitus **The conclusion of the inquest was:** Mrs Alden was assessed at very high risk of falls and required supervision when mobilising outside. On 13 September 2021 Mrs Alden, unnoticed and unsupervised, got up from her chair, walked through the communal area, opened an unlocked door and stepped outside. There she fell. Mrs Alden suffered severe head injuries and died as a result. Mrs Alden's death is contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Edith Alden had a history of falls and was admitted to The Limes Residential Home on 11 June 2021. Care Plan and Risk Assessments deemed Mrs Alden as being at a very high risk of falling and measures in place to control this risk included reference to staff monitoring her, supervision and mobilising with her frame plus the support of one carer. The evidence does not clearly reveal what the practical interpretation of these individual measures was. On 26 August 2021 Mrs Alden had an unwitnessed fall in her room. On 13 September 2021 Mrs Alden was sitting in a communal lounge. Four carers were present in the communal area carrying out handover. The door from the lounge area to the outside garden area was closed and unlocked. During handover, unnoticed and unsupervised and without the support of one carer, Mrs Alden got up from her chair, made her way out of the small lounge area, through the large lounge area, opened the patio doors and stepped out into the garden area. Mrs Alden was then heard to scream.

	Mrs Alden was found unresponsive lying on her back on the patio. Emergency services were called at 20.20 hours. Mrs Alden regained consciousness and was moved inside to keep her warm. On Mrs Alden's condition deteriorating emergency services were called again at 22.04 and 22.25. Emergency services arrived at 22.45 and Mrs Alden was taken to Norfolk and Norwich University Hospital where CT scan showed a subdural and subarachnoid haemorrhage. Mrs Alden's condition continued to deteriorate and she died on 25 September 2021.
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: 1. Care Plans and Risk Assessments were not consistent and clear as to what steps were required to mitigate the risks of Mrs Alden falling. 2. Staff were unclear in evidence as to what was required in respect of Mrs Alden to mitigate the risks of her falling. 3. Residents deemed as at very high risk of falls were, and still are, allowed in communal areas with no carer present. 4. Staffing levels may be insufficient for the number of residents. Evidence was heard that "*staff can't be everywhere at once*". 5. The Inspection Report dated 6 October 2022, carried out following Mrs Alden's death, found "*There were enough staff on duty to meet people's needs and people told us they never had to wait long for assistance. The registered manager had reviewed how staff were working and deployed staff in a way that meant that the right staff were in the right places when needed. This meant people in communal areas were never left alone ...".* This sentence is not supported by the evidence heard at inquest. 6. Residents deemed as at very high risk of falls were, and still are, in their bedrooms with a call bell and no other means to alert staff if they get out of bed and mobilise, this includes leaving their room and entering corridor areas. I am concerned this will lead to carers responding to a fallen resident, rather than preventing the fall.
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 June 09, 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], Next of Kin [redacted], Next of Kin [redacted], Next of Kin [redacted], Fosters Solicitors, Norwich (family legal)

	I have also sent it to: Care Quality Commission Healthwatch Norfolk 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: 16/04/2024** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH