	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Deerlands Residential Home, 48 Margetson Road, Parson Cross, Sheffield S5 9LS.
1	**CORONER** I am Tanyka Rawden, HM Senior 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 6 November 2023 I commenced an investigation into the death of Maureen Alison Woollen. The investigation concluded at the end of the inquest on 18 June 2024.
4	**CIRCUMSTANCES OF THE DEATH** Maureen Alison Woollen (born 24 September 1931) was discharged from the Northern General Hospital in Sheffield to Deerlands Residential Home in Sheffield on 2 October 2023. The S2A assessment identified she was a high risk of falls due to her underlying dementia and psychosis, her frailty, her limited mobility, the side effects of her medication and her previous falls. On admission to Deerlands residential home a falls risk assessment was not conducted. On 3 October 2023 Mrs Woollen was heard shouting and was found on the floor in her room. She could not say how she came to be on the floor. Staff did not identify any external injuries and did not seek medical assistance. On 6 October 2023 a carer noticed a 'fresh big bruise and a lump on her right forehead and temple'. A team leader was notified and decided to call an emergency care practitioner. This call was not made. Between 6 October 2023 and 13 October 2023 there are no references to Mrs Woollen's facial injury in the care notes. On 11 October 2023 staff noticed a decrease in Mrs Woollen's food and drink intake. This was not recorded in the care notes and medical assistance was not sought.

	On 13 October 2023 a general practitioner was contacted due to concerns from Mrs Woollen's family and Deerlands Residential home that Mrs Woollen had experienced a recurrence of psychotic symptoms over the previous two days. A general practitioner attended on 13 October 2023 and found Mrs Woollen to be 'slumped in a chair'. He was told the facial bruising occurred on 9 or 10 October 2023. There are no incidents recorded in the care notes on those dates. Mrs Woollen was admitted to Northern General Hospital in Sheffield on 13 October 2023 and diagnosed with an intracerebral haemorrhage. She died in hospital on 31 October 2023 as a result of the intracerebral haemorrhage.
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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The inquest found there were missed opportunities to conduct a falls risk assessment on Mrs Woollen's arrival to Deerlands Residential home, to seek medical attention when she was found on the floor on 3 October 2023, to seek medical attention when a bruise on her face was noted on 6 October 2023 and to monitor the progression of her bruise. The **MATTERS OF CONCERN** are as follows. - I am concerned there is no process in place to ensure medical attention is promptly sought for residents who require it, that care notes are not fully utilised, especially for the recording of injury and incidents, and that falls risk assessments are not being conducted on admission.
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 14 August 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: The family of Mrs Woollen. I have also sent it to Sheffield City Council who may find it useful or of interest. 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	19 June 2024 Signature  Tanyka Rawden H.M Senior Coroner for South Yorkshire (West)