	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Monarch Health Care C/O Heeley Bank Care Home,** [redacted]
1	**CORONER** I am Steve Eccleston Assistant Coroner for 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 8 April 2024 I commenced an investigation into the death of Mavis DEWEY. The investigation concluded at the end of the inquest on 07.08.24 The conclusion of the inquest was a narrative, namely: Mavis Dewey died on 29.03.24 at the Northern General Hospital Sheffield following a fall at the Heeley Bank Care Home Sheffield on the 23.03.24 when staff used incorrect equipment to help her stand in breach of her care plan. Her death was contributed to by neglect from Heeley Bank Care home. The Medical Cause of Death was: 1a Multiorgan failure 1b Covid 19 infection and open fracture of right proximal tibia and fibula 1c II Alzheimer's Disease, Heart Failure
	On 07.08.24 I heard the inquest touching the death of Mavis Dewey. Mavis was 89 years old and becoming frailer with a number of underlying health conditions. Her level of need was such that she required residential care which was provided by Heeley Bank Care Home in Sheffield. Mavis' needs were set out in her care plan and there was no dispute that, to be moved or mobilised, she required two members of staff to help her stand together with a standing aid and sling. On 23.03.24 Mavis was being assisted to stand by two members of staff in her own room. A stand aid was present in her room but so also was a Zimmer frame. It was not possible to establish how the Zimmer frame got there. Ms Davison for Monarch and Heeley Bank accepted that it was entirely

	inappropriate for the two members of staff to use the Zimmer frame to help Mavis stand, but this is what they did. As she was being helped to stand, Mavis asked to use the toilet. One member of staff left her with her colleague and supported on the Zimmer frame. Mavis legs gave way and she fell to the floor sustaining a severe gash to her right leg. An ambulance was called, and she was taken to the Northern General Hospital Sheffield where a fracture to the right proximal tibia and fibula was identified together with a diagnosis of Covid 19. Despite appropriate care in hospital, Mavis did not recover and she died there on 29.03.23 It remained unclear after evidence why the carers failed to comply with the care plan. I was taken to the care plan which was clear about how moving and handling should take place. The evidence from [redacted] was that no full reason was established as to why this happened. Rather, the fact was that the carers simply used the Zimmer frame which was to hand. She said that the carers had sufficient time to work with Mavis. I found that there was no good reason for what they did. This failure led directly to Mavis eventual death. In evidence it was stated by [redacted] that agency staff continued to fail to read care plans on occasion. This concerned me. The care plan sets out the essential requirements to ensure that a resident is safely cared for. I consider that if agency staff are not reading care plans then they may place residents at risk of harm or death just as Mavis was
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 **MATTERS OF CONCERN** are as follows. - (1) the admitted failure of agency staff, on occasion, to read care plans such that there can be confidence that residents are safe
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as the Chief Executive of the Monarch Group and operator of Heeley Bank Care Home 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 03.10.24. 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], son of Mavis I have also sent it to The Director of Adult Social Care Sheffield Council and to the CQC as regulator

	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	7 August 2024 Signature  Steve Eccleston H.M Assistant Coroner for South Yorkshire (west)