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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>Darnell Grange Nursing Home<br>84 Poole Rd<br>Darnall<br>Sheffield<br>S9 4JQ. |
| 1 | **CORONER**<br><br>I am Tanyka Rawden, Senior Coroner for the Coroner's area of South Yorkshire (West). |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br><br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br><br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 24 June 2024 I commenced an investigation into the death of Christiana Betty Dawson, known as Betty, aged 94. The investigation concluded at the end of the inquest on 10 October 2024. The conclusion of the inquest was a narrative conclusion as follows:<br><br>Christiana Betty Dawson fell at least ten times whilst a resident at Darnell Grange Care Home in Sheffield. On 16 March 2024 she fell and was moved into her bed by carers. Paramedics attended and identified a fractured left neck of femur. It cannot be said whether the fracture was caused by the fall or her being moved.<br><br>She underwent surgery to repair the fracture on 18 March 2024 and died on 19 March 2024 at the Northern General Hospital in Sheffield as a result of the fracture and her frailty.<br><br>Her falls risk assessments and care plans were reviewed after each fall, but no changes were made. An application to place her into nursing care was declined despite her increasing frailty and risk. Had further fall prevention measures been put in place, and had nursing care been provided, her falls may have been prevented |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Betty was admitted to Darnell Grange on 5 May 2020. She mobilised with a Zimmer frame and was a high risk of falls<br><br>Her falls risk was initially managed with an ultra-low-profile bed. A sensor mat was later put in place, but it is not known when.<br><br>There was no available evidence about any falls prior to 30 March 2022.<br><br>She fell, unwitnessed, on 30 March 2022, 23 May 2022, 23 September 2022 and 23 July 2023.<br><br>As a result of the fall on 23 July she sustained a right orbital fracture.<br><br>She fell again, unwitnessed, on 9 September 2023 and was admitted to hospital. The |

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| | Court heard Darnell Grange felt they could not accommodate her within their residential unit any longer and a nursing placement was required. The funding for this was declined and Darnell Grange accepted her back onto their residential unit despite accepting they could not manage her falls risk.<br><br>She fell again on 30 September 2023 and 16 December 2023.<br><br>On 24 January 2024 her anti-coagulation medication was stopped by her General Practitioner due to her frequent falls. Darnell Grange continued to administer the medication until her fall on 13 February 2024 when concerns were raised about this by attending paramedics.<br><br>She fell again on 13 February 2024 and twice on 16 March 2024. All but one of those falls was unwitnessed.<br><br>On 16 March 2024 she sustained an osteoporotic fractured neck of femur. After the second fall that day, was moved into her bed by staff. It cannot be said whether the fracture was caused by the fall or by Betty being moved after the fall.<br><br>She underwent a nailing of the right femur on 18 March 2024 and died in hospital on 19 March 2024 with a cause of death provided as:<br><br>1a. Osteoporotic fracture of right neck of femur (operated) and frailty of old age.<br><br>2. Vascular dementia and heart failure.<br><br>After every fall her care plan and falls risk assessment were reviewed and no changes made. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence 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.<br><br>The **MATTERS OF CONCERN** are as follows. -<br><br>The Court heard that changes had been made to alleviate the concern of a risk that future deaths could occur including:<br><br>i. Darnell Grange now have access to System One to be able to review prescribed medications.<br><br>ii. All falls are now referred to the occupational therapy team at their local surgery.<br><br>iii. All care plans are now reviewed with the local surgery and the resident's family.<br><br>iv. Darnell Grange no longer admits those with a high risk of falls.<br><br>However, the Court also heard that the nurse involved in moving Betty into bed after her fall on 16 March 2024 was from an agency. The evidence was that agency nurses are not trained on, or provided with, policies and procedures from Darnell Grange and therefore the nurse would not have known the policy was not to move a resident after a fall but to keep them comfortable and preserve their dignity until medical assistance arrived. The Court heard it was presumed from their nursing training they would know not to move a resident after a fall.<br><br>There is a clear risk of future deaths will occur if agency staff are not provided with home specific training, policies or procedures, not least given that it cannot be said whether the fracture was caused by the fall, or by moving Betty after the fall. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |

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| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 December 2024. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>i. Betty's family.<br>ii. Care Quality Commission, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | 16 October 2024<br><br>Signature  <br><br>Tanyka Rawden H.M Senior Coroner for South Yorkshire (West) |