Regulation 28: REPORT TO PREVENT FUTURE DEATHS

The Inquest Touching the Death of Sylvia Prichard
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **1** [redacted] Chief Executive Officer Avery Healthcare Group 3 Cygnet Drive Swan Valley Northampton NN4 9BS
1	**CORONER** I am Anna CRAWFORD, HM Assistant Coroner for Surrey for the coroner area of Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INQUEST** An inquest into Mrs Prichard's death was opened on 11 April 2024. The inquest was resumed on 26 September 2024 and concluded on 27 September 2024. The medical cause of Mrs Prichard's death was: 1a. Traumatic Acute Subdural Haemorrhage With respect to where, when and how Mrs Prichard came by her death it was recorded at Box 3 of the Record of Inquest as follows: Mrs Prichard was 91 years old and frail due to her age. On 28 March 2024 she had an unwitnessed fall at her care home as a result of which she sustained a head injury, resulting in her death at the Royal Surrey County Hospital on 3 April 2024. The inquest concluded with a short form conclusion of 'Accidental Death'.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Prichard had been assessed as being at high risk of falls. Some falls minimisation measures were recorded in her mobility care plan, however, she did not have a falls minimisation plan in place. Mrs Prichard had her own apartment at Moorlands Lodge Care Home. She had emergency buttons on the walls of her sitting room and her bedroom which could be used to attract immediate attention in the event of a medical emergency. She also had a call button on a pendant around her neck which could be used to alert staff that she needed routine assistance of any kind. At 10:11 on the morning of 28 March 2024 Mrs Prichard pressed her call button. The call button was responded to at 10:28, at which time Mrs Prichard was found on the floor. It is

	not known whether she pressed the call button before of after the fall. Following her fall she was unable to move so would have been unable to use the emergency button on the wall. Previously Moorlands Lodge Care Home was owned by a company called Signature, during which time there was a ten minute response time for call bells. However, in Summer 2023, Avery Healthcare acquired Moorlands Lodge Care Home, at which time a response time of two to five minutes should have been introduced in accordance with Avery Healthcare's policy. However, at the time of Mrs Prichard's death, the Manager of Moorlands Lodge Care Home was not aware of the Avery Healthcare policy and the home was continuing to aim to respond to call bells within ten minutes. It took seventeen minutes to respond to Mrs Prichard's call bell on the day of her fall, which was a twelve minute delay. The court found that this was not an isolated delay but was part of a broader pattern of delayed response times to call bells, including for Mrs Prichard but also other residents at Moorlands Lodge Care Home.
5	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is: - Mrs Prichard's mobility care plan contained out of date and conflicting information. The Coroner is concerned that other residents' care plans may contain out of date and conflicting information. - Mrs Prichard did not have a falls minimisation plan in place and the Manager of the care home was not aware that Avery Healthcare had a falls minimisation plan document which needed to be completed for residents at risk of falls. The Coroner is therefore concerned that other residents who are at risk of falls do not have falls minimisation plans in place. - Audits show that, despite efforts to improve call bell response times, a significant number of call bells are still not responded to within two to five minutes. This is of concern as residents who are unable to move due to a medical emergency or fall are not able to use the emergency buttons on the wall. - Since Mrs Prichard's death Moorlands Lodge Care Home has introduced watches which can be worn on the wrist and used to attract immediate attention in the event of a fall or other medical emergency. However, the watches have only been provided to residents who have been assessed as high risk of falls, meaning that others who have a fall, or another type of medical emergency, are still reliant on the pendant call button to gain assistance. - The Coroner is concerned that Avery Healthcare's oversight and auditing measures failed to identify that the call bell response time policy was not being implemented at Moorlands Lodge Care Home for many months and further failed to identify that falls minimisation plans were not being completed for residents.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that

	period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise, you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mrs Prichard's family 3. Care Quality Commission
9	**Dated: 25/10/2024**  **Anna CRAWFORD** **HM Assistant Coroner for Surrey for Surrey**