Response to the Coroner's Regulation 28 Report to Prevent Future Deaths

1.	**THIS RESPONSE IS MADE ON BEHALF OF** The Manor House Care Home
2.	**REGULATION 28 REPORT** This response follows a report by Jacqueline Lake, Senior Coroner for Norfolk.
3.	**INVESTIGATION AND INQUEST** On 22 February 2024, the Senior Coroner commenced an investigation into the death of John Riley, aged 73, who died on 8 February 2024 at The Manor House Care Home. The investigation concluded at the end of an Inquest on 15 November 2024, conducted by the Senior Coroner. The Senior Coroner gave a conclusion of Accident. The medical cause of death was: 1a) Neck fracture 1b) Fall
4.	**CIRCUMSTANCES OF DEATH** Mr Riley suffered life changing injuries in a road traffic collision in 1976 and was dependent on others for his care. Mr Riley entered The Manor House Care Home in 2017 and was provided with personal care. His mobility was severely limited. Risk Assessments found that Mr Riley was deemed at low risk of falling out of bed. His bed was to be placed at the lowest setting when unattended and he was subject to two hourly checks at night time. On 8 February 2024, Mr Riley was checked at 01.10 hours and 03.00 hours. When checked at about 05.25 hours, Mr Riley was lying on the floor with the bed frame under his neck. Emergency services were called and Mr Riley was declared dead at the scene. The evidence does not reveal the means by which Mr Riley came out of bed and onto the floor. Mr Riley died from a fracture to his neck.
5.	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows (as stated on the Coroner's Regulation 28 Report to Prevent Future Deaths): I. Evidence was heard that observations were sometimes not carried out every two hours as required. In January 2024 observations were late on

	ten occasions and on one prior occasion to 8 February 2024 in February 2024. II. Evidence was heard that some action has been taken by Manor House Residential Home to reduce late observations. Evidence was also heard that some observations are still being carried out outside of the two hour period.
6.	**ACTION TAKEN** The management at The Manor House Care Home has taken this matter very seriously. An internal investigation and Root Cause Analysis were undertaken following the incident, and the management at the home have continued to review their processes throughout, and following, the Senior Coroner's investigation into the death. The Manor House Care Home is a residential care home for 48 residents. Care is provided twenty four hours a day in shifts. Between 7pm and 7am, there is a senior carer supported by three night carers on duty. The care team undertakes welfare observations of every resident throughout the night shift. The NICE guidelines do not provide a standard for the frequency of welfare checks, but determine that every care home should ensure regular monitoring of residents' wellbeing based on the individual needs of its residents. The Manor House Care Home operates a system of two hourly welfare observations. The Manor House Care Home notes the concerns of the Senior Coroner. The Home wants to reassure all reading this report that they have reviewed their policy as to the frequency and timeliness of welfare observations, and that steps have been taken to address the concern that observations were sometimes not carried out every two hours as the Home requires of itself. In order to provide clarity, night staff previously undertook welfare observations in pairs. Care staff operated in pairs since should personal care also be required most, if not all, residents require two members of staff for the safe provision of their personal care. Each pair previously undertook the welfare observations for half of the residents within the home. Each pair of care staff moved from one resident to the next, administering personal care as required as they progressed round the home. The delays identified by the Senior Coroner occurred when residents required extensive personal care or attention during the welfare observation, which would then delayed the carers as they progressed to the next resident. Following the Inquest, The Manor House Care Home has made the following changes:

	1. Following the handover to the night staff at 7pm, each pair of care staff goes to their assigned areas. They undertake a walk around together whereby they check each resident. 2. Between 7pm and 9pm, those residents not already in their room are given the choice to be assisted to their rooms. 3. The two hourly welfare observations commence at 9pm and are undertaken thereafter at 11pm, 1am, 3am and 5am before the day staff commence their shift at 7am. 4. For the purpose of the two hourly welfare observations, the home is divided into four sections. Each staff member on duty is assigned a section for the duration of their shift. The home has a maximum capacity of 48 residents and so each staff member is assigned the duty of undertaking the welfare observations for a maximum of 12 residents. 5. Each staff member on duty is required to undertake a visual observation of each of their 12 residents at least every two hours. The individual members of care staff then re-join their partner upon completion of their respective observations to attend those residents requiring personal care in a priority order. 6. This approach ensures that welfare checks are undertaken at least every two hours without the prospect of the observations being delayed by the provision of personal care. 7. Welfare checks are recorded electronically via a handheld device onto the resident's social care record. The timeliness of the welfare observations undertaken the previous night is reviewed for five different residents daily by the Home Manager. This random, daily auditing process ensures that the timeliness of the welfare observations is monitored daily, which further ensures compliance. In conclusion, The Manor House Care Home wants to reassure all reading this report that the above actions are confirmed as embedded into practice as of the date of this response.
7.	**THIS RESPONSE HAS BEEN PREPARED BY** [redacted], Solicitor, DWF Law LLP on behalf of The Manor Care Home.
8.	**DATE OF RESPONSE** 10 January 2025