Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **The Manor House Care Home** **The Manor House** **Skeyton Road** **North Walsham** **Norfolk** **NR28 0LU**
1	**CORONER** I am Jacqueline LAKE, Senior Coroner for the coroner area of Norfolk
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.
3	**INVESTIGATION and INQUEST** On 22 February 2024 I commenced an investigation into the death of John Edward RILEY aged 73. The investigation concluded at the end of the inquest on 15 November 2024. **The medical cause of death was:** 1a) Neck Fracture 1b) Fall 1c) 2) **The conclusion of the inquest was:** Accident
4	**CIRCUMSTANCES OF THE 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 Manor House Residential 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** During the course of the investigation my inquiries 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.

	The **MATTERS OF CONCERN** are as follows: 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. Evidence were 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 SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 January 10, 2025. 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] (sister) I have also sent it to CQC Healthwatch Norfolk Department of Transport who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 18/11/2024** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH