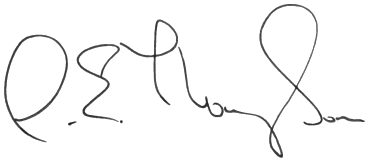
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted] - CEO - FOUR SEASONS HEALTHCARE**
1	**CORONER** I am James E THOMPSON, Assistant Coroner for the coroner area of County Durham and Darlington
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 02/05/2023 10:55an investigation was commenced into the death of Sylvia Margaret Louisa SAVAGE 16/09/1938 00:00:00. The investigation concluded at the end of the inquest on 12/12/2024 00:00. The conclusion of the inquest was that Sylvia Margaret Louisa Savage died on 25th April 2023 at the University Hospital of North Durham from bronchopneumonia. Her death was the the consequence of a fall from her bed and the injuries she sustained on the 18th March 2023 at the Redwell Hills Care Home, Consett, County Durham and commenced a decline in her health which despite medical treatment and care led to her death..
4	**CIRCUMSTANCES OF THE DEATH** Sylvia Margaret Louisa Savage died on 25th April 2023 at the University Hospital of North Durham from bronchopneumonia. Her death was the the consequence of a fall from her bed and the injuries she sustained on the 18th March 2023 at the Redwell Hills Care Home, Consett, County Durham and commenced a decline in her health which despite medical treatment and care led to her death.
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: (brief summary of matters of concern) 1. There was I heard no clear definition of when to report falls externally & internally - this to me is perhaps the reason why the fall Mrs Savage suffered on 1/2/23 was not recorded internally, all be it CQC were notified on this occasion. The fall on 18/3/23 was not reported to CQC and whilst I understand staff at the care home did not know the outcome of Mrs Savage's treatment in hospital - she left the home by ambulance and did not return. This seems an occurrence worthy of reporting— it strikes me some clearer reporting structure is necessary - timely and accurate reporting both internally and to regulators allows for those concerned to assess the care home and decide on whether there are risks/issues that need addressing and protect residents. I would suggest over reporting is preferable to under reporting.

	2. The evidence is clear that the provided sensor mat was not an efficient way of monitoring Mrs Savage when she attempted to mobilise. It was well known in the home that Mrs Savage defeated it's purpose by moving or unplugging it. There seems to have been a lack of thought as to an alternative measure. The wall mounted sensor, for example was seen by the expert as a reasonable measure - the home manager said he could consider them and the regional manager indicated they were used in the company, but not at the care home where Mrs Savage was residing. It seems to me the home should have an armoury of measures to pick from to tailor to the needs of the individual resident not just limited to one particular measure. The risk of death is obvious to others if persons at high risk of falls are not known to be moving by those charged with looking after them. 3. Mrs Savage's fall in February 2023 was it appears reported to her GP by her daughter and that led to a nurse attending the home to examine her. Staff at the home do not appear to have done so themselves. It is of concern that after a fall the staff within the home should have a mechanism to ensure medical advice is obtained in a timely fashion and that it is documented clearly and not be reliant on family members summoning help for residents themselves when they have become aware of an incident. 4. The absence of records has hindered my investigation into Mrs Savage's death. The expert in her evidence made it clear - good recording keeping allows staff to monitor changes in condition, allows new staff or those returning from time off to reacquaint themselves with residents condition and allows clinicians to make diagnosis - without access to good records I can see a clear risk to the care of residents. It is also surprising to me the complete reliance on paper records which have in Mrs Savage's case have been lost. I would have expected to see electronic recording of information and electronic storage of it. I note the roll out of this in the company has been paused whilst the company is awaiting sale and my concern is whether the electronic recording and storage will be implemented - to me immediate access to records of a resident or the absence of them creates a concern. 5. The evidence I have heard is after Mrs Savage's fall on 1/2/23 and when it became clear the sensor mat was not working as intended - this should have prompted staff to return to the care plans and re-evaluate them - it did not. Indeed one care home witness stated as Mrs Savage had not had 3 falls in 3 months no change to her plan was needed. Given the second fall Mrs Savage had some weeks later gave her injuries that led to her death this approach appears flawed. Whilst I acknowledge work is ongoing in this area it appears that prompt re-evaluation of the care plans after events such as a fall are necessary to prevent injury and death - I would ask for some reassurance that significant events are captured by staff and in turn their significance is carefully considered and if necessary changes made to care.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 February 12, 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]

	COUNTY DURHAM & DARLINGTON NHS FOUNDATION TRUST I have also sent it to **Care Quality Commission - Newcastle Upon Tyne** **[redacted] - DURHAM COUNTY COUNCIL - SOCIAL CARE** **[redacted] - INFORMATION COMMISSIONER** **OFFICER IN CHARGE - SAFEGUARDING DEPARTMENT DURHAM CONSTABULARY** 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: 18/12/2024**  **James E THOMPSON** **Assistant Coroner for** **County Durham and Darlington**