

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. Chief Executive Care UK</p>
1	<p>CORONER</p> <p>I am Benjamin Myers KC, Assistant Coroner for the coroner area of Greater Manchester South</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 24th April 2025, an inquest was opened concerning the death of Marion Jones, aged 73 at the time of death. The inquest concluded on the 31st July 2025.</p> <p>The medical cause of death was: 1a Traumatic Brain Injury, 1b Fall, 1c Squamous Cell Lung Cancer with Skin and Brain Metastases.</p> <p>The conclusion of the inquest was as follows [narrative]: Marion Jones died as a consequence of squamous cell lung cancer with skin and brain metastases in conjunction with the physical consequences of a fall.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Until January 2025, Marion Jones had led an active life. However, in January 2025, she was diagnosed with stage 4 lung cancer accompanied by a decline in her physical and mental condition. The cancer was inoperable and untreatable. The care was to be palliative within the community. After being cared for by her family, she went into respite care at Willow Woods hospice and from there to Riverside care home. Marion Jones was unstable in her movement and required the assistance of one or two carers for most physical activities, including getting in and out of bed.</p> <p>At Willow Wood, Marion Jones's bed had been fitted with bed rails. Prior to being admitted to Riverside, a pre-admission assessment was conducted by staff from Riverside. Although the relevant pre-admission form contains a section for assessment of safety equipment such as bed rails, no such assessment is recorded.</p> <p>Bed rails were not fitted to Marion Jones's bed at Riverside. Her family raised complaint about this on her admission to Riverside on 20th March 2025. They were assured that an assessment for bed rails would take place. No assessment did take place and on the 23rd March 2025 Marion Jones fell from her bed, which had not been fitted with rails. She landed on the floor, banging her head which caused visible injury, and which contributed to and hastened her physical and mental decline. The bed had been lowered but no crash mat had been put in place, contrary to the acknowledged requirement to do this. Had bed rails been in place this fall would not have happened. Marion Jones died on the 2nd April 2024.</p>

5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none"> 1. No pre-admission assessment for bed rails was recorded by the staff member responsible from Riverside, and this does not appear to have taken place. This is in circumstances where bed rails were already in place at Willow Wood and where there were obvious and recorded difficulties with regard to movement in and about bed, in addition to physical activity more generally. Given the circumstances, a pre-admission assessment for bed rails should have taken place and / or been recorded. 2. The inquest heard that family members raised their concerns on admission of Marion Jones to Riverside when they saw there were no bed rails. They were assured that an assessment would take place. This did not happen: it should have done. 3. The manager of the care home agreed that in all the circumstances, including the concerns of the family, such an assessment should have taken place. 4. A registered general nurse involved in care for Marion Jones, and who found her after she had fallen, gave evidence that an assessment for bed rails should have taken place 48-72 hours after admission. The manager of the care home gave evidence that such an assessment should take place as promptly as possible, and that 48-72 hours did not meet this requirement. The nurse did not appear to appreciate the time within which such an assessment should be conducted. 5. Another registered general nurse involved in the care of Marion Jones gave evidence that she was not sure in what period of time an assessment for bed rails should take place. 6. Therefore, nursing staff responsible for the care of Marion Jones did not know what the appropriate approach was to assessment for bed rails. The awareness of nursing staff at Riverside with regard to assessment for and / or the requirement for bed rails was not apparent 7. The inquest heard that there have been previous incidents where bed rails have not been in place.
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you (and / or your organization) have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd October 2025. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ol style="list-style-type: none"> 1. Daughter in law of Marion Jones, on behalf of the family

	<p>I have also sent it to:</p> <ul style="list-style-type: none">2. Tameside Metropolitan Borough Council - Adult Services3. Care Quality Commission <p>who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>7th August 2025</p>  <p>Benjamin Myers KC HM Assistant Coroner Greater Manchester South</p>