	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Managing Director, Mymill Ltd. c/o Scraptoft Court Residential Care Home, Scraptoft Lane, Leicester LE5 2HT**
1	**CORONER** I am Donald Coutts-Wood, Assistant Coroner, for the coroner area of Leicester City and South Leicestershire
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 11th February 2010 I commenced an investigation into the death of Marjorie Evelyne Keogh aged 89 years. The investigation concluded at the end of the inquest on 29th November 2013. The conclusion of the jury was Accident contributed by neglect. The cause of death was 1a. Bilateral pneumonia 1b. Multiple injuries II. Dementia.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Keogh was a resident at the Scraptoft Court Residential Care Home from January 2009. On the 6th March 2010 whilst transferring from her bedroom, on the first floor, to have breakfast in the dining room on the ground floor, she lost balance and fell through the balustrade on the first floor landing, falling to the ground floor. She sustained injuries and died the following day in the Leicester Royal Infirmary.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) On the admission of Mrs Keogh and at subsequent reviews there did not appear to have been an assessment of her suitability to occupy a room on the first floor. Please confirm that such an assessment is now completed, and provide written evidence of such a requirement. (2) Concerns were raised as to the staffing ratio to residents, and the lack of a manager at the home on that morning. The evidence indicated that as regards the latter point this was a regular occurrence. Please provide written evidence of current staffing requirements. (3) It seemed that there was evidence to indicate that there was conflict between the assessment of risk of falls and the assessment for manual handling, as to how serious a risk there was when Mrs Keogh mobilised. Please provide written evidence of how care plans and associated assessments are carried out. (4) Evidence indicated that the staircase furniture at Scraptoft Court did not meet strength requirements as stated in the plans for construction, nor British Standards and Building Regulations. I note that Scraptoft Court was constructed in the mid 1990s and shortly thereafter a further home was built called Syston Lodge. Is the staircase at that

	location compliant with the requirements referred to.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and / or Mymill Ltd. 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 28th January 2014. 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] (Family) Health and Safety Executive, Leicester City Council Care Quality Commission I am also under a duty to send the Chief Coroner a copy of your response. 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	**4th December 2013**