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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**Proprietors of Belgravia Care Home Ltd,**<br>**Belgravia Care Home**<br>**Promenade**<br>**Blackpool** |
| 1 | **CORONER**<br><br>I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde** |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>The death of Tina Murray on 8th January 2020 was reported to me and I opened an investigation, which concluded by way of an inquest held on 13th November 2020.<br><br>I determined that the medical cause of Tina's death was **1 a Suffocation.**<br><br>In box 3 of the Record of Inquest I recorded as follows:<br>*"Tina Murray had previously been diagnosed with paranoid schizophrenia and had had a history of self-harming behaviour. She resided in a care facility. Her presentation had been stable for a number of months. After being spoken to by staff during the morning of 8th January 2020 when no significant concerns were raised, Tina had a shower at around 11 am and remained in her room until approximately 11.50 am when she was found by care staff to be lay on her back on her bed and unresponsive. Tina had a white plastic bag which she had located in the care home secured over her head. Staff members immediately removed the bag and attempted cardio-pulmonary resuscitation. Paramedics were called and they transferred Tina to hospital where she was pronounced deceased at 13:38 hours. A subsequent post mortem examination confirmed that Tina died due to suffocation. The risk that Tina may seek to harm herself by gaining access to a plastic bag with the intention of voluntarily suffocating herself in order to end her life had not been fully recognized."*<br><br>The conclusion of the Coroner was that Tina Murray died due to **Suicide.** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>• Tina Murray was not a detained patient although she did reside within a care home reported to specialise in caring for clients with mental health conditions, |

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| | elderly clients, clients who suffer with dementia, and learning disabilities. She was able to move around within the home and not confined to her room.<br><br>• In around June 2019, care staff witnessed Tina to be in possession of a plastic bag and to infer that she may use the bag to harm herself. Staff were concerned about this, and indeed it was established at the inquest that care staff were reminded about this concern over subsequent months. However, I found that Tina had been able to access a plastic bag from within the care home. Evidence was received on the basis that the bag used by Tina had most likely been obtained from inside one of the bins located in the rooms of other residents.<br><br>• It appeared to me that should a resident be intent on locating a plastic bag from within the home they would be able to do so and in Tina's case with fatal consequences.<br><br>• Care staff were in my view placed in an impossible situation whereby on the one had they were being reminded that Tina gaining access to a plastic bag may be a concern but given that plastic bags were accessible within the building the risk posed to Tina could not be guarded against. |
| 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 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:<br><br>(1) Tina Murray posed a risk to herself, and specifically in relation to plastic bags, yet plastic bags appear to have been accessible within the home;<br>(2) Belgravia Care Home looks after residents who may not be detained but who do suffer from mental health conditions, dementia, learning disabilities and it is therefore important that risk assessments and safety measures in place at the Belgravia Care Home are robust. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you, **Proprietors of Belgravia Care Ltd**, have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **18th February 2021**. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: |

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| | • Lancashire & South Cumbria NHS Foundation Trust<br>• Head of Adult Services, Blackpool Council<br>• Care Quality Commission<br><br>and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)].<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | 22/12/2020<br><br>Signature_  <br>Alan Anthony Wilson Senior Coroner **Blackpool & Fylde** |