REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted], Managing Director of Tricuro
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 15th March 2022 an investigation was commenced into the death of Gerald Kenneth Tuck, born on the 17th June 1931. The investigation concluded at the end of the Inquest on the 11th August 2022. The Medical Cause of Death was: 1a Pneumonia 1b Immobility due to traumatic head injury 1c II Frailty Diabetes Cerebrovascular disease, Atrial Fibrillation, Dementia, Hypertension The conclusion of the Inquest was "Accident"
4	**CIRCUMSTANCES OF THE DEATH** The deceased, who suffered with dementia, became a resident at Sidney Gale House Residential Home, Bridport in January 2017. On the 25th December 2021 he fell at the home and was admitted to Dorset County Hospital, Dorchester. A CT scan did not reveal any head injury and he was subsequently discharged back to the home on the 27th December 2021. There is no record of a review of his falls risk assessment following his return. He was found on the floor in the home on the 27th January 2022 but was not thought to have sustained any injury. That day he was prescribed antibiotics for a suspected urine infection. There is no record of a further review of his falls risk assessment. On the 28th January 2022 he was found on the floor in his bedroom at the address and had bruising and a lump to his forehead. He was taken to Dorchester County

	Hospital where a CT brain scan revealed he had sustained 2 acute subdural haematomas. His condition deteriorated and he was discharged back to Sidney Gale House Residential Home on the 22nd February 2022 where he died on the 2nd March 2022.
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. During the Inquest evidence was heard that: i. Sidney Gale House Residential Home is governed by Tricuro Limited ii. Upon a person becoming a resident at the home, a care plan is put in place which requires a number of risk assessments to be undertaken. These risk assessments, and the care plan, are reviewed monthly. If there is an incident, such as a fall, the expectation is for the care plan and the risks to be further reviewed, however there is no formal policy, procedure or guidance document in place covering this. iii. On the 25th December 2021 the deceased fell at the home and was taken to hospital. He was discharged on the 27th December 2021. He fell again on the 27th January 2022 and again on the 28th January 2022 when the fatal injury was sustained. iv. The Registered Manager of Sidney Gale House gave evidence that his last falls risk assessment is documented to have taken place on the 16th December 2021. There is no evidence one was completed after this prior to the fatal fall on the 28th January 2022. The monthly review was due on the 31st January 2022 and there was no assessment recorded after the falls on the 25th December 2021 and 27th January 2022. 2. I have concerns with regard to the following: i. There is no written policy or guidance in place at Sidney Gale House Residential Home around the review of care plans following an incident at the home and this could lead to a future death is necessary risk assessments are not undertaken following an incident occurring.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 7th October 2022. 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: (1) Mr Tuck's family I have also sent a copy of my report to the following people who I believe have a sufficient interest in the contents of it: 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	**Dated** **12th August 2022**	**Signed** **Rachael C Griffin**