	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Registered Manager Care4U- Surrey and Director of Care4U Healthcare**
1	**CORONER** I am Caroline Topping assistant coroner, for the coroner area of Surrey.
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** **An Investigation was commenced on the Eleventh December 2023, and an Inquest opened on the Fourteenth December 2023, into the death of Peter McCarthy. The Inquest concluded on the Ninth October 2024.** **Peter McCarthy died on the 30th November 2023 from heart failure and pneumonia.** **The conclusion was that he died by Accident.**
4	**CIRCUMSTANCES OF THE DEATH** Peter McCarthy fell from his wheelchair at home on the evening of the 25th November 2023 when his wheelchair flipped over a slight ridge between the bathroom and corridor. He was not found until the following morning by his carer. She called an ambulance. She left the premises. Shortly thereafter a district nurse attended and made a further call to the ambulance which resulted in a quicker categorisation of the response. He was taken by ambulance to East Surrey Hospital and found to have sustained rib fractures and a subdural hematoma. He was given appropriate care, but he deteriorated and died on the 30th November 2023 from heart failure and pneumonia.
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. Following the inquest Care 4 U have put in place steps to ensure staff do not leave clients alone whilst they wait for ambulances. However, I remain concerned that: 1. On her arrival the carer offered Mr McCarthy his daily medications, which included an anticoagulant. He refused to take it. Following the conclusion of the inquest I sought information from Care4U Healthcare as to what, if any, protocol they have to ensure that clients who have fallen are not given anticoagulant medication without medical oversight. I have been told that medication comes in blister packs and the staff would not know if any medication was contra indicated after a fall. To date no protocol has been provided to the Court to deal with this type of situation.

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 4th February 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] The Care Quality Commission 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 other 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.
9	**Caroline Topping 10th December 2024**