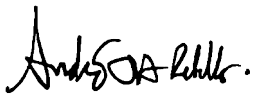
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Victoria Residential Home, Victoria House**
1	**CORONER** I am Andre REBELLO, Senior Coroner for the coroner area of Liverpool and Wirral
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 26 September 2024 I commenced an investigation into the death of Diane POOLE aged 83. The investigation concluded at the end of the inquest on 13 January 2025. The conclusion of the inquest was that: Diane Poole died from an Accidental death
4	**CIRCUMSTANCES OF THE DEATH** On the 31st August 2024 Diane Poole along with another resident left Victoria House Care Home through a faulty emergency escape door. The door was defective and the alarm did not sound. Staff in the residential home were unaware that Diane Poole was missing for three hours. Diane Poole was found following an unwitnessed fall on Steel Street, Wallasey. She was taken to the trauma centre at Aintree University Hospital where she was treated for head and facial fractures. She was discharged from Aintree University Hospital on the 17th September 2024 to Acorn House Residential Home. She died on 23rd September 2024. It is found that the fall and injuries more than minimally contributed to her death. It is unclear as to whether the fall would have occurred had she been noticed as missing earlier.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) The Court received evidence of the following: The investigation uncovered both the fault of the emergency exit door and a lack of awareness among the staff, highlighting the need for immediate corrective measures to prevent a recurrence of this incident. To address these issues, several actions will be implemented. Immediate corrective actions have been implemented to prevent a recurrence of this incident. Actions include: l Rigorous Alarm Checks: Regular inspections of all emergency exit alarms to ensure they are functioning correctly. l Increased Resident Headcounts: Staff will conduct hourly headcounts of all

	residents, with half-hour checks for those deemed high-risk. l Engaging Activities for High-Risk Residents: Structured, stimulating activities will be introduced to engage high-risk residents and reduce behaviours that may lead to attempts to leave the facility. l Improved Shift Handover Procedures: Shift handovers will be more resident-focused, ensuring clear communication and continuity of care. l Ongoing Staff Training: Regular training sessions will be conducted to reinforce the importance of supervision, resident safety, and emergency procedures. The Court seeks clarification that these actions have been implemented and are continuing
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 March 10, 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] I have also sent it to **CQC** Care Quality Commission, City Gate Gallowgate Newcastle upon Tyne Tyne and Wear NE1 4PA [redacted] who may find it useful or of interest. 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 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. They may send a copy of this report to any person who they 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: 13/01/2025**

	 **Andre REBELLO** **Senior Coroner for** **Liverpool and Wirral**