REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1 Manager/Director of Operations North Court Care Home, Maven Healthcare**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 24 November 2023 I commenced an investigation into the death of **Sonia Grace SORE** aged **84.** The investigation concluded at the end of the inquest on 23 January 2025. The conclusion of the inquest was: **Narrative Conclusion - Sonia Grace SORE was admitted to a care home in 2017 due to her requiring assistance with daily living needs. She had experienced a stroke in 2014 which had resulted in her suffering from right sided weakness and an expressive dysphasia. Mrs. SORE was at risk of further strokes for which she received treatment and also suffered from a heart condition (atrial fibrillation and congestive heart failure). In 2020 Mrs. SORE fell and suffered a right sided neck of femur fracture which further impacted on her already reduced mobility. By 2023 Mrs. Sore only had mobility on her left-hand side and required to be hoisted into and out of her bed and made use of an electric wheelchair to mobilise.** **Mrs. SORE had been assessed as at risk of falling from her bed and in 2023 the management plan to address this risk included her bed rails being raised when she occupied her bed. Mrs. SORE had expressed repeated objections to the raising of the right handrail on her bed. On the early morning of the 14th October 2023 Mrs. Sore fell from her bed onto the floor. The right handrail on her bed was not raised and had not been raised prior to this point as per the risk management plan to address her falls risk. Mrs. SORE was assessed and no obvious injury could be identified. Emergency services were consulted with advice given to monitor Mrs. SORE's condition and escalate should any concerns arise. A review by care home staff of Mrs. SORE's risk assessment occurred on the 14th October 2023.** **On the 17th October 2023 a nurse at the care home made an entry in Mrs. SORE's notes confirming the requirement for the bed rails on Mrs. SORE's bed to be raised when she was occupying it. The right handrail was not raised following this note and was not raised between the 14th October 2023 and the 20th October 2023.** **On the 20th October 2023 Mrs SORE experienced another fall from the right-hand side of her bed and was found on the floor of her room beside her bed at around 1845 hours. She had fallen in the same manner as the fall on the 14th October 2023. Again, Mrs. SORE was assessed and no obvious injury could be identified.**

	Emergency services were consulted with advice given to monitor Mrs. SORE's condition and escalate should any concerns arise. **Mrs. SORE's condition deteriorated on the 25th October 2023 and she was seen by a General Practitioner who advised the care home call 999 and for her to be transported by ambulance to hospital. On arrival at hospital Mrs. SORE was assessed as having suffered a large left acute subdural haematoma. Following input from specialist neurosurgical clinicians, it was determined that her condition was unsuitable for surgical intervention and that she would be best cared for through conservative management of her condition. Mrs. SORE's condition deteriorated on the 28th October 2023 and a decision was taken in conjunction with her family for Mrs. SORE to be discharged back to her care home for palliative care. This occurred on the 1st November 2023 and Mrs. SORE sadly passed away a week later on the 8th November 2023.** **It is not possible to identify when the bleed on Mrs. SORE's brain first started, however it had commenced at some point prior to the 25th October 2023 when she started to show symptoms of her condition. It is probable that the fall on the 20th October 2023 made a material contribution to her injury and death. The fact that the right-hand bed rail was not raised on Mrs. SORE's bed meant that she was able to fall out of bed on the 20th October 2023 and this fact made a material contribution to the death.** **Sonia Grace SORE died due to accidental causes.** The medical cause of death was confirmed as: **1a Subdural Haematoma**
4	**CIRCUMSTANCES OF THE DEATH** **Narrative Conclusion see Box 3**
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: **During the course of hearing evidence it was apparent that within North Court Care Home there was a less than diligent focus on risk assessment and mitigation.** **Despite risks being assessed, and mitigation measures identified, staff would regularly fail to implement the latter. In Mrs. SORE's case this included the failure to secure the right hand side bed rail as identified in numerous risk assessments relating to mitigating her risk of falling from the bed. The evidence indicated that this applied in relation to the actions of multiple staff at the care home, not just a few, giving rise to the concern that this was a cultural problem at North Court Care Home**
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 August 12, 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 **The Family of Sonia SORE** I have also sent it to **Care Quality Commission** **Swan Surgery, Bury Saint Edmunds (Mrs SORE's GP Practice)** who may find it useful or of interest. I am also under a duty to send a copy the Chief Coroner. 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	**Dated: 17/06/2025**  **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**