

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

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"> <li>1. [REDACTED], Chair, Cornwall &amp; Isles of Scilly Integrated Care Board,</li> <li>2. [REDACTED], Chief Executive, Royal Cornwall Hospitals NHS Trust,</li> </ol>
1	<p><b>CORONER</b></p> <p>I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 16/2/26, I concluded the inquest into the death of Geoffrey Gudgeon who died in Poldhu Nursing Home, Mullion on 1/12/24 at the age of 89.</p> <p>I recorded the cause of death as 1a) Ischaemic stroke.</p> <p>I recorded a conclusion that Geoffrey died from Natural Causes.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On 11 June 2024, Geoffrey suffered a spontaneous ischaemic stroke. He was admitted the next morning to West Cornwall Hospital where, after a CT scan, his diagnosis was confirmed. [REDACTED], WCH consultant contacted the stroke unit at RCHT and [REDACTED], clinical lead for the stroke service, felt it was clinically appropriate for Geoffrey to be transferred to Phoenix ward at RCHT. At that time, however, no beds were available on the ward.</p> <p>Shortly thereafter, a request was made for a rehabilitation bed at Camborne &amp; Redruth Community Hospital. Again, no bed was available.</p> <p>Geoffrey's presentation fluctuated. In early July, it was felt it would no longer be in his best interests to be transferred to CRCH due to low mood. On 30 July, approximately six weeks after admission to WCH,</p>

	<p>Geoffrey was transferred to Penhallow reablement unit - on the family's evidence, without prior discussion with them. He was seen by a stroke nurse on 5 August who felt Geoffrey's needs were greater than the unit could meet. He was transferred the same day to Royal Cornwall Hospital. Two safeguarding referrals were made which culminated with a referral to the police.</p> <p>On 15 August, Geoffrey was transferred to Poldhu Nursing Home where he remained until he died. The police have confirmed no criminal offence has been disclosed. The safeguarding investigations appear to have been closed after it was established he was in a suitable Home.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>During the course of these inquests, the evidence has 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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows.</p> <ol style="list-style-type: none"> <li>1) The inquest heard evidence from [REDACTED], stroke consultant, that, at the time of these events, only 35% of patients were admitted to a stroke unit from an ED within 4.5 hours, while only 55% of patients were spending over 90% of their time on a stroke unit. Further, that there were approximately 80 admissions of stroke patients/month or about 900/year. The obvious concern was that there was a capacity issue in Cornwall concerning the timely admission and treatment of stroke patients.</li> </ol>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p> <p>The inquest was told that an identified increase in the mortality rates of stroke patients in Cornwall has been identified and that an action plan has been drawn up to address the issue. None of the plan's detail was available for the inquest.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 April 2026. I, the coroner, may extend the period. A joint response from [REDACTED] will be acceptable.</p> <p>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain</p>

	why no action is proposed.				
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <ul style="list-style-type: none"> <li>- Family of Mr Gudgeon;</li> </ul> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>				
9	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><b>[DATE]</b></td> <td style="width: 50%; border: none;"><b>[SIGNED BY CORONER]</b></td> </tr> <tr> <td style="border: none;">16.2.26</td> <td style="border: none;"></td> </tr> </table> <p>cc Dr Adie</p>	<b>[DATE]</b>	<b>[SIGNED BY CORONER]</b>	16.2.26	
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