

**IN THE SURREY CORONER'S COURT**  
**IN THE MATTER OF:**

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**The Inquests Touching the Death of John William Tugwell**  
**A Regulation Report – Action to Prevent Future Deaths**

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	<p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>Coombe Dingle Nursing Home, 14 Queens Park Road, Caterham, Surrey. CR3 5RB</p>
1	<p><b>CORONER</b> Martin Fleming ADC Surrey</p>
2	<p><b>CORONER'S LEGAL POWERS</b> I make this report under paragraph 7, Schedule 5, of the coroners and Justice Act 2009 and regulations 28 and 20 of the Coroners (Investigations) Regulations 2013</p>
3	<p><b>INVESTIGATION and INQUEST</b> On 16<sup>th</sup> April 2013 I opened an inquest into the death of <b>John William Tugwell</b> who, at the date of his deaths was aged 79 years. The inquest was resumed and concluded on 22<sup>nd</sup> November 2013 I found that the cause of death to be: - 1a. Bilateral lobar pneumonia 1b. Acute subdural haemorrhage and cortical contusions I concluded with Accidental Death.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b> On 6<sup>th</sup> April 2013 Mr John William Tugwell was found at the bottom of the stairs following an unwitnessed fall at the nursing home where he was a resident. At the hospital he was found to have sustained skull fractures and an extra cranial scalp haematoma. Very sadly he was not considered fit for surgery and he subsequently succumbed to his injuries on 9<sup>th</sup> April 2013.</p>

5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>During the course of the inquest the evidence revealed a matter that gave rise to concern and which, in my opinion, there is a risk that future deaths could occur by reason thereof unless action is taken.</p> <p>The <b>MATTER OF CONCERN</b> is as follows. –</p> <ul style="list-style-type: none"> <li>• Although Mr Tugwell was clearly a falls risk given his documented history of previous falls at the home, he was allowed unsupervised access to the two sets of stairs at the home.</li> </ul> <p>I would be grateful if you could re consider the appropriateness of allowing such vulnerable and unsupervised residents access to the stairs given the potential for serious injury.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe that Coombe Dingle Nursing Home have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.</p> <p>Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.</p>
8	<p><b>COPIES</b></p> <p>I have sent a copy of this report to:</p> <ul style="list-style-type: none"> <li>• [REDACTED]</li> <li>• [REDACTED]</li> <li>• [REDACTED]</li> <li>• [REDACTED] Surrey Police</li> <li>• [REDACTED] CQC</li> <li>• [REDACTED] Surrey Safeguarding Adults</li> <li>• Chief Coroner</li> <li>• Coroners Society for England and Wales</li> </ul>

9	<b>DATED this 1<sup>st</sup> December 2013</b>