REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Kent County Council, Corporate Director Social Care, Health and Wellbeing.
1	**CORONER** I am Allison Summers Assistant Coroner, for the coroner area of Mid Kent & Medway.
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 the 30th April 2013 an investigation into the death of Alan Ludlow was commenced. The investigation concluded at the end of the inquest on the 22nd October 2015. I reached a narrative conclusion.

4	**CIRCUMSTANCES OF THE DEATH** Alan Ludlow died at Maidstone Hospital on the afternoon of Sunday 24th March 2013. He was 84 years old. He had been admitted to hospital at about 5.30am on the 21st March. The reason he had been admitted to hospital on that morning was because at about 4.15am, carers at the nursing home where Mr Ludlow resided, had found him in an unresponsive state in his bathroom. Having been taken to hospital a head scan showed a massive subdural haematoma. Following consultation with experts at Kings College Hospital it was determined that due to Mr Ludlow's frailty he would not survive the operation necessary to save his life. He was therefore managed conservatively. Mr Ludlow subsequently developed pneumonia which led directly to his death. As to the cause of the head injury, on the evening of 20th March Mr Ludlow had received a blow to the left side of his face from another resident (RT). I was satisfied that it was that blow which caused the bleed which ultimately led to Mr Ludlow's death. Both Alan Ludlow and RT were residents at Lulworth House, a Residential Home for elderly adults with dementia and related illnesses. Both gentlemen were elderly. Mr Ludlow was 84 years old and RT was 77 years old. Both gentlemen had dementia although Mr Ludlow's dementia was at a much more advanced stage. Both presented at times with what may be properly called 'challenging behaviour' entirely in keeping and associated with their declining mental and physical states. The circumstances giving rise to the blow to Mr Ludlow can be stated as follows: On 20th March 2013 shortly after 7.30pm when the nightshift staff had arrived at Lulworth House, Mr Ludlow and RT became involved in an altercation. They were observed to be arguing with raised voices when a member of the domestic staff, [redacted], saw RT punch Mr Ludlow striking Mr Ludlow in the left eye area causing his head to turn to the side. The punch did not knock Mr Ludlow off his feet and Mr Ludlow was immediately seen to raise his own fists.

	A member of the domestic staff (ML) quickly intervened and her raised voice alerted one of the carers, TC who came and helped diffuse the situation. The incident was brought swiftly to an end and the two residents went their separate ways. There was nothing in RT's notes to suggest any violent tendencies above and beyond those you may reasonably expect a person with his level of dementia to have. ML did not mention to any of the other staff at that stage, that she had actually seen RT strike Mr Ludlow. It was later in the evening, at about 9pm when ML told one of the carers, TC, about the punch. At about midnight, TC assisted Mr Ludlow to bed. At that time, he commented that his head "felt funny" or may have said it was "hurting" but does not appear to have been exhibiting any other obvious signs of injury or distress. No action to report the matter to the senior carer or seek any medical assistance was taken. As was customary practice, another carer SJ, looked in on Mr Ludlow twice between him going to bed at about midnight and being found at about 4.15am. She observed that Mr Ludlow was in bed asleep. At 4.15am TC looked into Mr Ludlow's bedroom to find his bed was empty. She subsequently found him on the toilet in an unresponsive state. Paramedics were called and on arrival immediately noticed that Mr Ludlow's pupils were different in size and that he had a black-eye. He was taken to hospital but as I have already indicated due to his otherwise frail state of health surgical intervention was not considered appropriate and he declined and died.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern as to the exchange of information. 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. The **MATTERS OF CONCERN** are as follows. –

	One of the matters which became apparent during the course of the evidence related to the issue of ensuring that when someone is assessed for a particular placement within residential and nursing environments that those undertaking the assessments and the home in which a person is placed, have all relevant information to ensure that the placement is the most appropriate for that person. Once a person is placed in a home the suitability of that placement must be kept under review to ensure that any changing needs continued to be met. It stands to reason if people are not appropriately placed there will be risks of harm to both themselves and to others. The specific issue which came to my attention in this case was this: After the incident between Mr Ludlow and RT, RT was moved from the home to other accommodation. However, more recently, following deterioration in his mental state, he was admitted to another care home. This care home was not provided with any information about the incident which led to Mr Ludlow's death by RT's social worker or those who would be expected to know about the incident. The only reason the care home in fact became aware of the background was because it was part of the same group of care homes to which the original care home belonged and it was only by chance that someone recognised the name and made the connection.
6	**ACTION SHOULD BE TAKEN** There has to be in place a clear policy so that relevant information which will or may affect the suitability assessment is disclosed by Social Services or other bodies to those undertaking the assessment and if different, to the home where the person is or may ultimately be placed.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18/1/16. I, the Assistant 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] (family of deceased) Nellsar Care Homes (Lulworth House) [redacted] was an interested party but due to his mental state played no part in the proceedings, a copy of this report is to be sent to his daughter on his behalf. I am also under a duty to send the Chief Coroner a copy of your response. 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.
9	**23rd November 2015**