Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Hampshire County Council, Adult Services
2 Manager Oakridge House Residential Home

1 CORONER

I am Jason PEGG, Area Coroner for the area of Hampshire, Portsmouth and Southampton

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 21st April 2020 I commenced an investigation into the death of Arthur Edward JOHNSON aged 85. The investigation concluded at the end of the inquest on 5th January 2021. The conclusion of the inquest was: Accident

The Medical Cause of Death was:
I a Intracerebral Haemorrhage

I b Fall

I c

II Spontaneous intracranial haemorrhage, Hypertension, Alzheimer's Disease

4 CIRCUMSTANCES OF THE DEATH

The deceased died on 20th April 2020 at the Royal Hampshire County Hospital, Winchester, Hampshire. The deceased suffered an unwitnessed fall on 17th April 2020 at Oakridge House Residential Home in consequence of which the deceased suffered a head injury and intracerebral haemorrhage. The deceased had also suffered a spontaneous intracranial haemorrhage which contributed to the death of the deceased.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:
Oakridge House Residential Home is staffed by non-medically trained personnel.
The "Post-Falls" process/policy direct that 999/111 should be called when a head injury is suspected.
The evidence at inquest indicated that where a head injury was considered a possibility 999/111 was not called.
My concern is that the present process does not give adequate direction, provide sufficient clarity nor distinguish between "possible" and "suspected" head injury. It is not clear when 999/111 should be called.
Further, I have concerns in relation to the training provided to assist Residential Home staff in the recognition of intracranial injury.

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 02 March 2021. 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] (Spouse).
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.

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Jason PEGG
Area Coroner for
Hampshire, Portsmouth and Southampton
Dated: 05 January 2021