




**Derek Winter DL**  
**Senior Coroner for the City of Sunderland**

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>Chief Executive of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust</b> <b>Secretary of State for Health and Social Care</b></p>
1	<p><b>CORONER</b></p> <p>I am Derek Winter DL, Senior Coroner for the City of Sunderland</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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 5<sup>th</sup> December 2018 I commenced an Investigation into the death of Richard Burgess, who was born on 5<sup>th</sup> February 1939 and who died at The Holy Cross Home Sunderland on 30<sup>th</sup> November 2018 aged 79 years. The Investigation concluded at the end of the 3-day Inquest on 12<sup>th</sup> May 2021. The conclusion of the Inquest was 'Richard Burgess was a risk to himself and from others and those risks were not sufficiently and proactively managed and exposed Richard Burgess to harm', the medical cause of death being: - 1a Aspiration Pneumonia 1b Cerebral Amyloid Angiopathy and Blunt Head Injury</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Richard Burgess died at Holy Cross Nursing and Residential Care Home, Sunderland on 30<sup>th</sup> November 2018 after being punched 3 times to the head on 31<sup>st</sup> August 2018 by another patient who was also detained under the Mental Health Act 1983 at Monkwearmouth Hospital, Sunderland.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>During the course of the inquest the evidence 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> <p>I did not have a sufficient level of confidence about:</p>

	<ul style="list-style-type: none"> <li>• the provision of a multidisciplinary team of professionals with suitable skills, qualifications and competencies commensurate with their role and the specialty of dementia care;</li> <li>• a prevention model and approach for dementia care that proactively uses detailed assessment, intervention and evaluation of changing care, needs and risks of the individual in order to provide therapeutic interventions and reduce the need for medication;</li> <li>• the evidence of assessments or the application of assessments of the impact of a person’s difficulties, including cognitive and neurological difficulties, polypharmacy, psychological and personality, mental and physical health, social, environmental and care practices, emotions, belief and thoughts of the person;</li> <li>• a continuous engagement with the family in the “triangle of care”, including regular communication and updating life stories;</li> <li>• a focus on the person, asserting absolute value of the person, an individualised approach, while understanding the world from the person’s perspective and provision of a social environment that supports psychological and physical needs;</li> <li>• converting policy into practice.</li> </ul> <p>The Trust had done a lot of work since the death of Mr Burgess, and I should also be pleased to hear from the Secretary of State about wider learning for other Trusts.</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 you 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 the date of this report, namely by 15<sup>th</sup> July 2021. I, the Coroner, may extend the period.</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 why no action is proposed.</p>
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</li> <li>• Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and their Solicitors</li> <li>• Care Quality Commission (CQC)</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	<p>Dated this 19<sup>th</sup> day of May 2021</p> <p>Signature </p> <p>Senior Coroner for the City of Sunderland</p>