	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] – Owner-Clifton Court Nursing Home (Crosscrown Ltd)** **2. Family of Mrs. Dorothy Seekings** **3. Chief Coroner** **4. Care Quality Commission**
1	**CORONER** I am Sean McGovern, senior coroner, for the coroner area of Warwickshire
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 21st September 2019, I commenced an investigation into the death of Dorothy Seekings 87 years old. The investigation concluded at the end of the inquest on 7th July 2021.The conclusion of the inquest was a Narrative Verdict.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Seekings was resident at Clifton Court Nursing Home in Rugby. She was a frail elderly lady who could neither speak nor walk. She was highly vulnerable. During the night of 8th August 2019 another resident of the home entered her room. It is not clear why he went into her room but he suffered from dementia and may have thought he was in his room which was next door. A carer entered Mrs Seeking's room at approximately 4.00am and discovered she was dead. Lying next to her on bed was the other resident who was fully clothed. A post mortem examination showed she had died of blunt force injuries. On the balance of probabilities those injuries were caused by the other resident. He was arrested that night but was assessed as being unfit to be detained or interviewed. Subsequently he was detained under Mental Health Act. I am satisfied that he was suffering from rapidly deteriorating Vascular Dementia and on 8th August 2019 could not form the mens rea for any form of unlawful killing. He died on 5 May 2020. Although the events of 8th August 2019 were not reasonably predictable I

	record that there was ineffective promulgation of the care plan for the other resident and occasions of physical violence to care and nursing staff (but not to fellow residents) by the other resident largely around his personal care (washing, bathing), which were missed opportunities to trigger a re-assessment of his overall risk
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) the care plans for [redacted] did not record incidents where [redacted] had acted aggressively to staff members including an occasion when a staff member was kicked in the mouth by [redacted]. (2) the failure to raise a safeguarding alert with the local authority regarding the above incident. (3) The staff did not appear to be aware of the contents of the care plan for [redacted] or other resident
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you - [redacted] - 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 2nd September 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] & [redacted] (daughters). I have also sent it to the Care Quality Commission who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**7th July 2021** **Sean McGovern**