M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

11th January 2022 [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Management, Blenheim House Care Home**
1	**CORONER** I am Myfanwy Buckeridge Assistant Coroner for **Area of Avon**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 04/08/2021 I commenced an investigation into the death of Reginald Howard Weston. The investigation concluded at the end of the inquest. The conclusion of the inquest was Accident
4	**CIRCUMSTANCES OF THE DEATH** Mr Weston died due to injuries sustained in a fall on 7 July 2021. It was identified in evidence that he had moved and bypassed the sensor mat that had been placed at his feet and that care staff were aware he had done so on previous occasions. Although the presence of an in-place sensor mat unlikely made a difference in Mr Weston's fall, it may do so in different circumstances where a resident is known to bypass the sensor mat. He had fallen twice on 4 July 2021 but there was no evidence to indicate his falls risk assessment was reviewed following those falls and recorded as required by the Majisticare Falls Management Policy and Procedure.
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 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. – Evidence was given in relation to the Majesticare Falls Management Policy and Procedure requirement to record a review of the resident's risk assessment in the context of 2 recorded falls on 4 July 2021. Blenheim House management need to consider: a) Documentation demonstrating a review of the resident's risk assessment has taken place following a fall b) Timely process for completing it

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 8th March 2022. 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 – the family of the deceased. 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	11/01/2022 Signature  Myfanwy Buckeridge Assistant Coroner **Area of Avon**