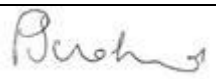
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **The Manager** **Pelham House (Cedarcare (SE) Ltd** [redacted] **Cuckfield** **West Sussex** **RH17** [redacted]
1	**CORONER** I am **PENELOPE SCHOFIELD**, senior coroner, for the coroner area of **WEST SUSSEX**
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 22nd January 2018 I commenced an investigation into the death of Mildred Horrex, aged 85 years. The investigation concluded at the end of the inquest on 3rd October 2018. The conclusion of the inquest was that Mildred Horrex died an "Accidential death". At the conclusion of the Inquest indicated that I was minded to make a Regulation 28 report. Regretably whilst the indication to make a Regulation 28 report was made in October 2018 it appears to have been missed and was not issued until June 2020 for which I apologise.

4	**CIRCUMSTANCES OF THE DEATH** On 30th December 2017 Mrs Horrex, who was left sleeping in a chair in her room at Pelham House, suffered an unwitnessed fall in which she suffered a fracture to her C1 and C2 vertebrae in her neck. She was taken to hospital but sadly did not recover from her injuries and she died on 18th January 2018.
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. – 1. During the course of the Inquest it was clear that overall the record keeping in respect of Mildred was poor. There was insufficient information taken about Mildred by the home before her admission to Pelham House, the information that was taken was at times inaccurate and this lead to an inadequare fall risk assessment being insufficient. 2. Whilst the drugs chart showed that Mildred was taking her medication regularly the amount of medication that was found after her death showed that this could not be the case. We were told that monthly drugs audits were apparently carried out but they did not pick up the decrepancies in the recording on the drugs charts and the amount of medication held.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 4th August 2020. 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 Mildred Horrex [redacted] 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	**Date 8th June 2020**

	 **Penelope Schofield, Senior Coroner**