REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **European Care c/o Plexus Law, Vale Chambers, Evesham Worcs WR11 4EJ**
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and Central)]
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 of October 2013 I commenced an investigation into the death of Clive William (DOB 31.12.62) who died on the 21st of October 2013 at Cae Glas, 82 Vale Street, Denbigh. The investigation concluded at the end of the inquest on the 20th of May 2013. The conclusion of the inquest was that the death arose from Natural Causes and the medical cause of death was Epilepsy Related to Parkinson's Disease.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased had been a resident at Cae Glas Psychiatric Rehabilitation Care Home where he had passed away in bed on the 21st of October 2013.
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) Evidence was given by the family of Mr Clinton that they had complained to the manager of the Care Home on several occasions about the standard of care which was being provided to Mr Clinton, namely that they would often find him drenched in urine and faeces, that his soiled bedding and clothing would be left in his room, that there were occasions when he would not receive his prescribed medication and that he would sometimes medical appointments which had been arranged for him. (2) Evidence was also given by a representative of European Care who own the care home, confirming that although a complaints procedure exists within the organisation, the concerns of the family in this instance had not reached a senior level as should happen so that action could be taken.

	(3) My concerns relate to the apparent failings of a complaints procedure in which staff can effectively withhold concerns from senior management and the lack of information within the care home that could advise persons with concerns as to how they may direct their complaints to a more senior level of management within the organisation. In the absence of a truly robust system of complaint, it is possible that concerns may not be addressed in a timely fashion or at all and could ultimately place residents at risk of harm.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 18th July 2013. 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] and [redacted] (Mother and Brother of the Deceased, CSSIW 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] 23rd May 2013** **[SIGNED BY CORONER]**