## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used after an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	1. Lifestyle Care plc
1	CORONER
	I am Stephanie Haskey, assistant coroner, for the coroner area of Nottinghamshire
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 25 <sup>th</sup> April 2014 I commenced an investigation into the death of Beryl French, aged 79, who died on 28 <sup>th</sup> April 2013. The investigation concluded at the end of the inquest on 25 <sup>th</sup> April 2014. The conclusion of the inquest was that Beryl French died as a result of a pulmonary embolism as a result of a deep vein thrombosis with Dementia as a contributory factor, and a Conclusion of Natural Causes was given.
4	CIRCUMSTANCES OF THE DEATH
	Beryl French was a resident at Landmere Nursing Home in Nottinghamshire. She got into respiratory difficulties whist receiving personal care. Nursing staff were summoned and decided to make no active interventions as they believed that a completed Do Not Attempt Cardio- Pulmonary Resuscitation (DNACPR) form was in place. This was not the case.
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. That there was a lack of understanding amongst nursing staff at Landmere about the nature of DNACPR forms and the information that should be provided for them to be complete and appropriate to be relied upon.  Although the evidence disclosed that no active intervention would have saved Mrs French, and that in was in her best interests not to intervene, this might not be the case in other, similar circumstances.  2. That End of Life Care planning was insufficient to guide nursing and care staff to help residents to die peacefully and with dignity in appropriate cases.
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. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 26<sup>th</sup> June 2014. 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: 1. The family of Beryl French I have also sent it to: 1. The Care Quality Commission 2. Nottinghamshire County Council Adult Safeguarding 3. The Nursing and Midwifery Council who may find it useful or of interest. 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. ISIGNED BY CORONER [DATE] 30<sup>th</sup> April 2014 Stephanie Haskey