REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: **1. The Salvation Army** **2. The Manager, Villa Adastra Care Home**
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 29 April 2014 I held and concluded an inquest (and investigation) into the death of Stanley Bere, aged 89 years old. The formal conclusion was that Stanley Bere, died on 4th June 2012 from congestive cardiac failure and bronchopneumonia. He had been immobile for some time following an assisted fall on 31st October 2011, some 8 months earlier, in which he suffered a fractured ankle. This fractured ankle together with the subsequent infection contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Bere had been a resident of the Villa Adastra nursing home since December 2009. He had during that time suffered a number of falls. On 31st October 2011 he had another fall. An incident report was completed where it was noted that he had suffered no injuries. The fall was not recorded at the time on the home's Cardex system. Mr Bere had in fact sustained a serious injury in the fall to his ankle. It then appeared that there were many missed opportunities by the staff at the home to spot these injuries.. The family raised concerns on a number of occasions but it was not until 8th November 2011 that action was taken and the true extent of Mr Bere's injury was discovered. His ankle had been fractured in two places which was required to be pinned in the Hospital.. After this procedure he returned back to the Care Home. A few weeks later the District nurse realised that one of the implanted screws was visible and the area was infected. Again this was not picked up by the Care Home. Mr Bere was readmitted to hospital where the screws were removed and the infection was treated. As a result of the ongoing infection all the metalwork had to be removed and this took place on 23rd May 2012. Sadly Mr Bere did not recover from this medical intervention and he slowly deteriorated and died on 4th June 2012.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – (1) There was evidence provided at the Inquest that showed that the Cardex system used at the home was not being properly completed. Dates, on occasions, appeared to be out of order and important information such where a patient had fallen was not being recorded. Family concerns also did not appear to always be recorded. (2) Incident reports were being completed but in Mr Bere's case his incident report was not followed up or updated even when further information was available as to the extent of Mr Bere's injury. (3) The lack of cross referencing or monitoring of these Cardex system and the Incident reports appears to have been the reason why Mr Bere's injuries were not picked up soon by staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR 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 **29th August 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 – [redacted] **(Mr Bere's daughter) and Goodlaw, Solicitors,** 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	**4th July 2014** SIGNED – ***Penelope Schofield*** (Senior Coroner – West Sussex)