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. Mr Warren, Owner of Baron's Park Nursing Home**
1	**CORONER** I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and South
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 28 – 30th July 2014 I commenced an investigation into the death of Christopher John Royal, 67 years. The investigation concluded at the end of the inquest on 30th July 2014. The conclusion of the inquest was Cause of death - 1a Aspiration of stomach contents 1b Ischaemic heart disease Conclusion – Natural causes contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Mr. Royal was properly detained under a DOLS order, Mental Capacity Act 2005 which prevented him from leaving Baron's Park Nursing Home. He suffered a cardiac event on 25 January 2013 and was found collapsed in his en-suite bathroom that evening. Staff attending to Mr. Royal from the Nursing Home but did not provide any, or any adequate First Aid. Paramedics were summoned but Mr. Royal was pronounced life extinct as CPR was unsuccessful.
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) Mr. Royal was on 15 minute observations. The observations were not carried out by a designated member of staff; there was no system in place; the recorded observations were unreliable and inaccurate; recordings were not made by the staff who had actually observed Mr. Royal. Consideration should be given to a more robust, safe and accountable observation system, and proper training and auditing to ensure this is in place and operating effectively.

	2) Evidence was taken that the Matron did not have a valid First Aid Certificate at the time of this event; it had expired in 2011. There was evidence that the nursing home staff response to this medical emergency was inadequate and insufficient. One member of staff said although First Aid trained she did not feel competent to carry out CPR. First Aid training is essential in a Nursing Home environment, and there should be in place a proper system to ensure training is provided, updated, effective and understood. An annual system of review and/or appraisal may assist in the monitoring process and allow staff feedback and concerns reporting. 3) Matron said she regularly worked a 13.5 hour shift as it meant less travelling time as many staff lived a distance from the home. This length of shift may not be conducive to good health care and may have contributed to the poor care given that evening to Mr. Royal. Consideration should be given to whether shifts of this length are for the benefit of the residents or the staff, and if any perceived benefits outweigh any potential problems this type of shift pattern may create.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 27th September 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 - East Midlands Ambulance Service NHS Trust - [redacted] brothers of the deceased - Coventry Social Services - Coventry and Warwickshire Partnership Trust I have also sent it to the - Care Quality Commission and 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.
9	**30 July 2014**