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. MPS [Investments] Ltd** **2. Care Quality Commission** **3. Nesbit Law Group [Solicitors for the Clarkson family]**
1	**CORONER** I am Simon D A Jones - H.M. Area Coroner, for the coroner area of Preston and West Lancashire.
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 29th July 2013 I commenced an investigation into the death of Dorothy Mavis Clarkson, aged 78. The investigation concluded at the end of the inquest on 10th September 2014. The conclusion of the inquest was that the cause of death was 1a Respiratory arrest due to 1b Inhalation of food with significant contributory factors at 2 Ischaemic heart disease, valvular heart disease and previous intracerebral haemorrhage. The conclusion in Box 4 was that Dorothy Mavis Clarkson died an accidental death, contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** DMC choked on a large piece of meat while eating her meal at Longton Nursing and Residential Home on the 25th July 2013 at approximately 1255hrs and became unresponsive. Initial attempts at resuscitation by staff at the home were unsuccessful, but paramedics who arrived shortly after were able to clear her airway and re-establish circulation. She was taken to Royal Preston Hospital where her condition deteriorated and she died on the 27th July 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) the procedure by which food is provided and presented to residents who require food to be prepared in a certain way and who need assistance by virtue of their physical or mental condition; and (2) a lack of training appropriate to nursing staff working in a nursing home being undertaken by qualified nursing staff to satisfy the on-going professional development requirement of the Nursing and Midwifery Council.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 28 November 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 – Nesbit Law Group, as solicitors for the deceased's family. I have also sent it to the Care Quality Commission 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	26th September 2014 ..... S D A Jones – Area Coroner.