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Regulation 28 – Report to Prevent Future Deaths

This Report is being sent to:
Quality Care Commission, Citygate, Gallowgate, Newcastle upon Tyne NE1 4PA
Corporate Director Childrens Adults and Families, South Tyneside Council, Town Hall & Civic Offices, SOUTH SHIELDS NE33 2RL

1 **Coroner**

I am Terence Carney, Senior Coroner for Gateshead & South Tyneside.

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made
http://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made

3 **Investigation & Inquest**

On 10th October 2011 I commenced an investigation into the death of EDWIN THOMPSON, aged 77 years. The investigation concluded at the end of the inquest on 14 November 2014. The conclusion of the inquest was Natural Causes contributed to by neglect.

4 **Circumstances of the Death**

The deceased a 77 year old retired shipyard worker diagnosed with front lobal dementia was admitted initially early in 2011 for respite care but later as a long term patient to a residential home Conolley House in South Shields dedicated to the exclusive care of individuals diagnosed with dementia. He was found dead in a bathroom of the Home on 8 October 2011. The post mortem examination confirmed the cause of Mr. Thompson's death was the natural consequence of a previously undiagnosed cardiovascular disease. Further investigation has confirmed that this natural cause of death was in part contributed to by :-

a) Inadequate and inconsistent protective measures for the welfare and safety of a known vulnerable individual and the behavioural risks presented by his known Dementia.
b) Leading to a missed opportunity at an early stage on the presentation of potential cardiac related symptoms to summon medical assistance
c) The temporary but critical loss of contact with an individual with propensity to wander and
d) The consequent second missed opportunity to respond to a final medical crisis leading to his demise

5 **Coroners 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 matter of concern are as follows:-

A The seeking of medical advice and assistance.
There is a need to draft and disseminate to all care staff a clear, simple and concise directive to care home staff to seek medical advice or assistance in respect of residents presenting with pain, particularly of a cardiac nature without delay.
Staff with no medical qualification must not seek to speculate as to possible causes of symptoms and should not seek to medicate (unless otherwise previously prescribed by a Medical Practitioner) or prescribe "remedies" of no or no known worth to anyone in their care.
B As to Training
Training in the practices and protocols within the establishment should be formalised, regularised and directed as a personalised package to all staff. It should be the subject of planned periodic review and revision throughout the year and an integral part of the established annual appraisal of staff members and their performance.
The quality and effectiveness of in house training provision should be an integral and essential element in and of the periodic appraisal of management performance.
C As to record keeping
The accurate recording of incidents affecting the care and management of residents is an essential tool in keeping staff informed of the needs of residents in order that the staff can be better able to react respond and plan for the essential needs of residents.
The quality of the recording of notes must be evaluated by management on their regular reviews of residents care notes and staff must be made aware in a timely fashion of any shortcomings in the notes and their content. Assistance to improve in the recording of notes must be given an urgent priority in any training needs and recognised as a significant performance issue if there is consistent failure to adhere to the expected standard.
Ultimately and aspirationally a computer based system of record keeping would be the preferred option, but the lesson of effective record keeping in whatever format, has to be reinforced by regular and effective file checks by Managers.

6 **Action Should be Taken**

In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 9th March 2015. 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 & Publication**

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons {NAMES} {and to the Local Safe-Guarding board (where the deceased was under 18)}. I have also sent it to the {NAMED PERSON} 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.

Date: 22nd December 2014 **{Signature}**

Senior Coroner – Gateshead & South Tyneside