REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr. John Alder Chief Executive University Hospitals of Leicester ("UHL")** **2. Dr. Peter Miller Chief Executive Leicester Partnership Trust ("LPT")**
1	**CORONER** I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and Leicestershire 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 18 August 2014 I commenced an investigation into the death of Henry Denis Whitwell Powell 95 years. The investigation concluded at the end of the inquest on 5th February 2015. The conclusion of the inquest was cause of death was 1a Bronchopneumonia 1b Immobility 1c Head Injury II Dementia Conclusion : accidental death contributed to by neglect .
4	**CIRCUMSTANCES OF THE DEATH** Mr. Powell was suffering from advanced dementia and requiring 24 hour care in St Georges care home. He was recovering from a hospital stay following a fractured neck of femur and had been discharged with equipment that had been ordered by the hospital including bed rails, a profile bed and air mattress. Due to ineffective communication the home were not provided with appropriate documentation and had no discussions regarding the use of the equipment, and so this continued in place from his discharge on 23 May 2014. He then had a further fall when he got out of bed, climbing over the bed rails, on 1st August. On this occasion he suffered a head injury and died from this on 11th August 2014 without regaining consciousness.
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 discharge care planning was inappropriate and there was a significant misunderstanding regarding the intended and appropriate use of the bed rails which suggested insufficient training of discharge staff. (2) There is a conflict currently between the policies governing transfer arrangements

	between hospital (UHL) and community (LPT) and the provision and ordering of equipment, which can now be done directly by the hospital. (3)Co-ordination between services is inadequate, resulting in equipment being ordered by the hospital but not thereafter being followed up or assessed in the community. (4) Equipment is supplied by a single gatekeeper, NRS Healthcare, and an alert system is intended to ensure communication has taken place between all stakeholders, but I was advised this system has not been implemented; early implementation would assist in resolving the current difficulties.
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 14th April 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 and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons. [redacted] (Adult social care), [redacted] (Care home manager), [redacted] (Daughter), [redacted] (Daughter), [redacted] (Daughter) and [redacted] (Son). I have also sent it to, CQC NHS England NRS Healthcare ICES chair – [redacted] 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	**[DATE]** 18/2/2015 **[SIGNED BY CORONER]**