REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: (1) [REDACTED] Manager, Berrycroft Manor Care Home.** **(2) Head of Adult Social Care, Stockport Metropolitan Borough Council.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 14th January 2015 I commenced an investigation into the death of **Sidney Barnett** dob 7th February 1924. The investigation concluded on the 12th June 2015 and the conclusion was one of **Natural Causes**. The medical cause of death was 1a Bronchopneumonia 1b Dementia 11. Coronary Artery Atheroma and Type 2 Diabetes Mellitus.
4	**CIRCUMSTANCES OF THE DEATH** **The deceased was resident at a Care Home for the elderly. He was gradually declining in health. On the 21st December 2014 he was in his room and was seen by his relatives to be without socks, he had the remnants of his dinner all over the front of his clothes, he was unshaven and he was struggling to eat a bowl of custard, alone and unattended.** **The following day his relatives again visited him at the home and he was seen to be wearing only a T shirt and was sitting in his chair close to a window which was open, even though it was late December and the weather was cold. Later that evening he was seen by a District Nurse who was there to administer his insulin, and she, through the out-of-hours doctor, immediately admitted him to hospital where he died from pneumonia on the 3rd January 2015.**
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. **Whilst at Berrycroft, the level and quality of observation of the client appears to have been inadequate.** 2. **There was an insufficiency of care shown to the deceased in terms of his general welfare (whether he was warm enough, whether he was washed and shaved, whether he was able to take his meals safely, whether his clothing was adequate and clean etc.).**

	3. The 'cleaner' at the care Home "opens the windows, whatever.." There seemed to be no clear rule in place as regards the appropriateness of the windows being open. **[Items 1to 3 should be addressed by Berrycroft]** **4. As a result of these matters a safeguarding alert was raised by the hospital team, and this was investigated by the Adult Safeguarding Team at the Council. Both a member of that investigation and the Chairperson of the meetings, agreed that the level of inquiry had been inadequate and that they ought not to have concluded that the 'complaint' was unsubstantiated.** **5. The system for looking into these matters is vague and unstructured and will inevitably lead to an insufficiency of investigation. Too much reliance is placed on what the "Care home" employees say, without testing that and further querying what actually happened.** **[Items 4 and 5 to be answered by S.M.B.C.]**
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 **7th August 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 namely [redacted] **(half-brother of the deceased)**. I have also sent it to **CQC** 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	**12.6.15** **John Pollard, HM Senior Coroner** [redacted]