ANNEX A

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. [redacted]** **Directors** **New Park Residential Home** **Chilvelstone Grove** **Trentham** **Stoke-on-Trent** **ST4 8HN** **2. Director Adult Social Care** **Stoke-on-Trent City Council** **Civic Centre** **Glebe Street** **STOKE-ON-TRENT** **ST4 1HH**
1	**CORONER** I am Margaret J Jones, assistant coroner, for the coroner area of Stoke-on-Trent & North Staffordshire.
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 28th October 2014 I commenced an investigation into the death of Janine Eugenie Pierette KAISER. The investigation concluded at the end of the inquest on 13th July 2015. The conclusion of the inquest was that Mrs Kaiser died from significant natural disease with a contributing sacral ulcer the progress of which had been compromised by gaps in her nursing care. The cause of death was given as- 1a Lobar pneumonia. II Suppurative cystitis, sacral pressure ulcer and aortic stenosis, multiple myeloma, stroke.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of multiple myeloma, aortic stenosis, atrial fibrillation, stroke and urinary tract infection. She was bed bound. She became resident at New Park Nursing Home, Chivelstone Grove, Trentham, Stoke on Trent in December 2013. She was on occasions non- compliant with feeding, fluid and turning regimes. She developed a sacral pressure ulcer and tissue viability nurses were involved. Her management plan was not always followed and nursing records were found to be inaccurate. On the 15th October 2014 tissue viability nurses found her pressure mattress not alternating and with the alarm turned off despite twice daily records recording it as having been checked and in order. She died at the home at 8.20pm on the 21st October 2014. The cause of death was given as lobar pneumonia, suppurative cystitis, sacral pressure ulcer, aortic

	stenosis, multiple myeloma and stroke.
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 deceased had in place a management plan for dealing with her pressure sores. The plan was not adequately followed; turns were missed leaving long periods when the deceased remained unturned. Records were not appropriately kept when the deceased declined intervention. Records had been falsified and turns recorded when they had not been done. It was not possible to identify which member of staff had completed the forms. Nursing staff were not available to take calls from the Tissue Viability Nurses. 2. Records were difficult to interpret and did not accurately record times at which fluid and food had been offered to the deceased. The amounts taken by the deceased were not adequately recorded. 3. Staff appeared inadequately trained in record keeping. 4. There was poor continuity of staff. 5. Twice daily pressure mattress checks were fully completed indicating an appropriately functioning mattress. However when a mattress check was made by Tissue Viability Nurses the mattress was not alternating and the fault alarm on the mattress had been turned off. The attention of the staff was drawn to this but it was not subsequently recorded in the deceased's records. The staff were inadequately trained in pressure mattresses management. They apparently checked that the mattress had a power source but did not check that the mattress was functioning correctly. 6. Referral to Tissue Viability nurses should have been done sooner. 7. The deceased had lost a considerable amount of weight but there was no referral to a dietician (although the GP had been consulted regarding her weight loss and had prescribed supplements) The importance of the supplements was not fully appreciated by all of the staff. The deceased's weight was maintained during a hospital stay but deteriorated on her return to New Park Nursing Home 8. The deceased was incontinent and had required cleaning before Tissue Viability Nurses were able to examine her. 9. Single agency staff investigating Adult Protections Referrals had closed their investigation and recorded the allegations as unsubstantiated without obtaining full details of concerns raised by other professionals.
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 Friday 11th September 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:- 1. [redacted] (daughter of the deceased) 2. [redacted] social care assessor. 3. [redacted] Operations Manager, New Park House. 4. [redacted] GP 5. [redacted] Staffordshire Police 6. [redacted] Corporate Governance Manager, Staffordshire & Stoke-on-Trent NHS Partnership. 7. CQC. 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	14/7/15 [redacted]