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:** **Newton House [formerly Regency Hospital]** **183 Newton Drive** **Blackpool** **FY3 8NU**
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
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 2015 I opened an investigation into the death of Dennis Peter Stark aged 47 years. The inquest concluded on 1st October 2015. The conclusion of the Coroner as to the death was one of Natural Causes. The medical cause of death was: 1 (a) Hypoxic brain injury 1 (b) Community acquired pneumonia .
4	**CIRCUMSTANCES OF THE DEATH** Dennis Peter Stark suffered from paranoid schizophrenia and was detained at a rehabilitation unit in accordance with Mental Health legislation. At approximately 0900 hours on 27 May 2014 he was found unresponsive in his bedroom on the second floor. An ambulance arrived at 0911 hours. An attending paramedic noted that he did not have a pulse. After three cycles of cardio pulmonary resuscitation a pulse was recorded at approximately 0932 hours. He was taken to hospital arriving with a Glasgow Coma score of 3. Despite subsequent treatment he proceeded to deteriorate. Clinical observations confirmed evidence of pneumonia which lead to him suffering a loss of oxygen to the brain which proved fatal.

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. During the course of the Inquest I heard evidence from a Paramedic Reynolds who had been called to Regency House (now Newton House) which is a rehabilitation unit that cares for individuals with mental health issues, Mr Stark having previously been diagnosed as suffering from schizophrenia. He was an obese gentleman who weighed in excess of 30 stones, and he had been found unresponsive in his room. He was residing in a second floor room at the premises. The premises have no lift. The Paramedic indicated that after her arrival, there followed a period of time during which Mr Stark had no pulse and required Cardio Pulmonary Resuscitation. However, once a pulse was noted it then took the ambulance crew approximately twenty-two minutes to leave the scene. She clearly felt that the time it took the crew to leave the premises was contributed to by the absence of a lift in the premises and to the extent that she felt at least half of the amount of time it took to leave the scene could have been avoided had a lift been in place. In reality Mr Stark had to be transported with some difficulty from his room, down some steps, and out to the ambulance and then taken to hospital. It could not be established from the evidence whether that increased amount of time contributed to Mr Stark's eventual demise but I am concerned that a risk of future deaths may arise should someone requiring urgent medical attention be accommodated on the second floor of Newton House whose physical status is such that safe removal of that person from the building may be compromised and leave paramedics in similar difficulties. Although evidence was provided by the Nursing staff that when this gentleman was mobile he was able to use steps at the premises to get around, it appeared to me that there had been insufficient thought given to the prospect of him requiring urgent medical attention and whether his size may hinder his removal, particularly in the event of an emergency. At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Trust by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009.
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 24TH December 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 The family of Dennis Peter Stark The Coroners Society of England & Wales The Chief Coroner of England & Wales Care Quality Commission 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	A.A. Wilson **Alan Wilson** **Senior Coroner for Blackpool & The Fylde** **Dated: 30th October 2015**