REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Nant y Gaer Hall Nursing Home, Nant y Gaer Road, Llay, Wrexham
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and Central)
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 16th of October 2014 I commenced an investigation into the death of Peter Scott Furness then aged sixty six. The investigation concluded at the end of the inquest on the 30th of September 2015. The conclusion of the inquest was Accidental Death, the medical cause of death being 1(a) Choking on a Latex Glove (b) Dementia.
4	**CIRCUMSTANCES OF THE DEATH** 1. The Deceased, who had been diagnosed with Frontal Lobe Dementia, was a resident at the Nursing Home which provides care for persons with dementia. 2. He was known to be at risk of placing non-edible items in his mouth and had been observed doing so on a number of occasions. 3. Although risk assessments had been undertaken he collapsed on the 13th of October 2014 and was verified dead at the home at 12.32 hours. 4. A Post Mortem established that he had choked on a latex glove and two further gloves were found in his stomach which had been ingested previously.
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. – The Registered Individual responsible for the care home and the current Manager both acknowledged that within current systems and protocols operating at the home, there is no documented process by which incidents or concerns are escalated so as to result in a multi disciplinary team meeting aimed at reviewing the risk assessments and care plan relating to the vulnerable person within their care.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 30th of November 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 Person, [redacted] (Widow of the Deceased). 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] 5th October 2015** **[SIGNED BY CORONER]**