REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Shawe Lodge, 1,Barton Road, Urmston M41 7NL: [redacted] Podiatrist:**
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 7th March 2015 I commenced an investigation into the death of William Gordon Tolen dob 12th January 1933. The investigation concluded on the 14th October 2015 and the conclusion was one of **Natural Causes**. The medical cause of death was 1a Septicaemia 1b Cellulitis and 11 Coronary Artery Atheroma .
4	**CIRCUMSTANCES OF THE DEATH** **Mr Tolen was living at Shawe Lodge from the 29th January 2015. On the 10th February it was noted that he had a problem with his legs and the GP attended and cream was prescribed. Thereafter it was also noted that he had a problem with the nail on his left great toe. The podiatrist attended and , inter alia, she removed the toe-nail which she stated was already detached from the toe. This procedure was carried out in the sitting room area of the home. Mr Tolen went on to develop cellulitis in his legs, although this was not apparently directly linked to the removal of the nail.**
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 quality of note recording and keeping at the home fell a very long way short of what might be considered satisfactory. The effect of this was that the member of staff giving evidence was unable to confirm many facts because they were simply not recorded either properly or at all.(Shawe Lodge)** **2. The need for the attendance of a podiatrist was, or should have been apparent to the staff at the home, and yet they allowed 5 days to pass without ensuring that their messages had been received, hence there was a delay before Mr Tolen was seen and treated.(Shawe Lodge)** **3. The witness from Shawe Lodge confirmed in evidence that the staff did not have any training in relation to dealing with this type of matter and that the nurses were not trained as to the fact that they could and should**

	contact the Clinical manager in such cases. **4. Following this death, there has been no form of investigation by Shawe Lodge to review procedure, training or protocols within the home. (Shawe Lodge)** **5. The notes at Shawe Lodge indicated that the nail had been removed from the "right" great toe when in fact it was the left. This was apparently due to a misinterpretation of an abbreviation in those notes. (Shawe Lodge)** **6. The details kept in the daily "Diary" at the home were grossly inadequate, an example being "chase up podietry (sic) for William" on the 19th February. He was known as Gordon. No-one appears to have pursued this or noted that the podiatrist did not attend until the 24th February. The whole system of notes being kept in a diary, in a separate individual note file, in MDT visits book and in a GP visits book appears inevitably to lead to confusion.(Shawe Lodge)** **7. The Podiatrist attended and was left with the patient in the sitting room. The Shawe Lodge staff did not remain and did not offer to assist with his removal to a more suitable location for the procedure to take place. (Shawe Lodge)** **8. The podiatrist carried out a procedure in the sitting room. She had to remove food debris and other detritus from around Mr Tolen's feet before she could put down plastic sheets. This practice rendered both Mr Tolen and other residents at risk of infection and it was wholly inappropriate to carry out such a procedure in this way [redacted]** **9. Extremely late in the inquest hearing, I was informed by the attending staff from Shawe Lodge, that Mr Tolen was subject to a D.O.L.S order when he was resident there. This information, which subsequently proved to be erroneous, could have been of vital importance.(Shawe Lodge)**
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 10th 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 namely [redacted] (wife of the deceased). I have also sent it to **C.Q.C** 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	**15.10.15** **John Pollard, HM Senior Coroner**