REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Nursing Director, Alexander Court Care Centre, 320 Rainham Road South, Dagenham, RM10 7UU**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Eastern Area of Greater London
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 13th November 2015 I opened an investigation into the death of Mr Harold Goulding. The investigation concluded at the end of the Inquest on the 13th July 2016. The conclusion of the Inquest was a narrative conclusion. *Mr Harold Goulding suffered 2 falls in his care home on the 5th and 6th November 2015. He was admitted to hospital on the 6th November 2015 where end stage heart failure and an acute on chronic subdural haematoma were diagnosed. On the 10th November 2015 he suffered a seizure from which he did not recover. The most likely cause of the fatal seizure was the trauma of the falls and consequent head injury.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Goulding suffered a fall at the Alexander Court Care Centre in the early hours of the 5th November 2015. He was seen by a GP on 5 November 2015 who checked him for fractures. The GP was not aware that Mr Goulding was on warfarin therapy and there was no record of any assessment for a head injury. The GP had not received reports from the anti-coagulation clinic and he did not check the Care Home's medication administration record. Mr Goulding suffered a second fall on the 6th November 2015. He was taken to hospital following the second fall. The main clinical concerns at this time were of shortness of breath, swollen neck and swollen arms/legs. The initial impression upon attendance to hospital was of end stage heart failure. A CT scan carried out on the 7th November 2015 confirmed an acute on chronic subdural haematoma. Mr Goulding remained in hospital and was stable until the 8th November 2015 when it was noted that he was suffering from swallowing difficulties. His family also noted an increase in his level of confusion at this time. On the morning of the 10th November 2015 he suffered from a seizure. Despite anti-epileptic medication and management of his airway, he suffered a cardiac arrest. Life was pronounced extinct at 09:46 on the 10th November 2015. At the Inquest the cause of death was found to be 1a cardiac arrest 1b seizure 1c fall, head injury and subdural haematoma (on warfarin therapy). 2 congestive cardiac failure; type 2 diabetes and hypercholesterolemia.

5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – 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: 1. The evidence revealed a breakdown of communication between the anti-coagulation clinic, the General Practitioner and the Care Home. The Care Home had registered Mr Goulding with a new General Practitioner but did not notify the anti-coagulation clinic of the details of the new General Practitioner. The community pharmacist therefore continued to provide reports to the old GP. 2. The General Practitioner provided the lead in relation to the administration of medication at the care home. The General Practitioner did not however consider the Medication Administration Record held by the home. The staff providing evidence from the care home agreed that it would reduce risk in the future, if a system is in place to ensure that the General Practitioner attending for new resident reviews, considers and approves the medication set out within the Medication Administration Record. This would not only provide assurance to the Care Home staff in relation to medication that they are administering, but would also ensure that GPs are fully aware of the medication that residents are currently receiving. It was further agreed that in order to reduce future risk, the Care Home staff should take the lead in ensuring that any other health agencies providing care to new residents are informed when the home registers new residents with a new General Practitioner, so that information can be correctly shared.
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 **9th September 2016**. 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, [redacted] (daughter of the deceased), [redacted] (GP). I am also forwarding a copy of the report to the Care Quality Commission and to [redacted] (Director of Public Health) 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	**[DATE]** 14.7.16 **[SIGNED BY CORONER]**