**for Stoke-on-Trent & North Staffordshire**

| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>1. **Mr Matthew Tee**<br>**Chief Executive Officer**<br>**Care First Homes**<br>**17-19 Leek Road**<br>**Cheadle**<br>**Stoke-on-Trent**<br>**ST10 1JE** |
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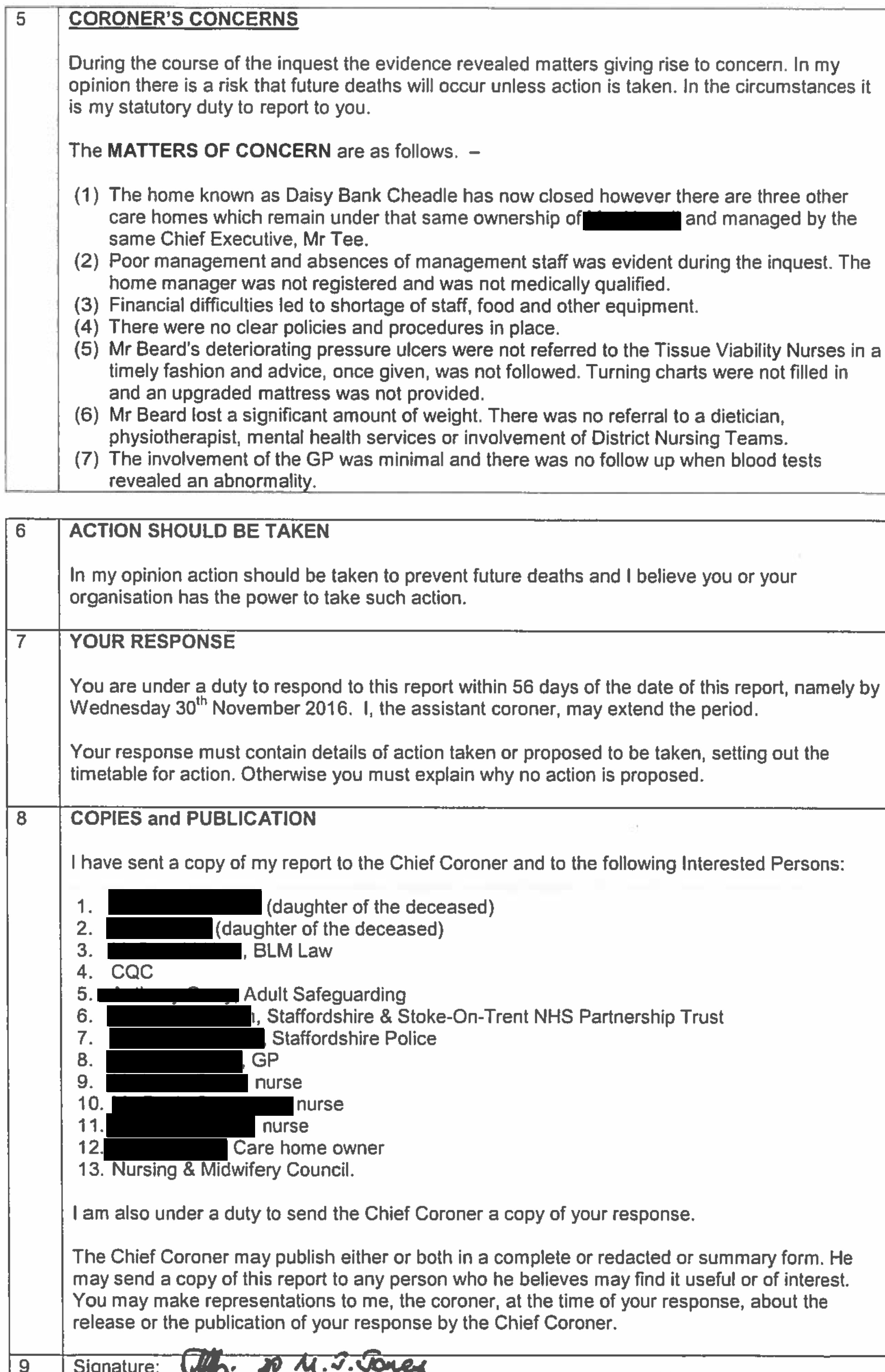
| 1 | **CORONER**<br><br>I am Margaret J Jones, assistant coroner, for Stoke-on-Trent & North Staffordshire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 25th February 2015 I commenced an investigation into the death of Norman Arthur BEARD aged 87 years. The investigation concluded at the end of the inquest on 27th September 2016. The conclusion of the inquest was that Mr Beard died from infected pressure sores to which neglect contributed. The cause of death was given as:-<br>1a. Sepsis.<br>1b. Infected pressure sore.<br>II. Urinary tract infection. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The deceased suffered a fall at his home address on 9th October 2014. He was admitted to the University Hospital North Staffordshire and transferred to Leek Moorlands hospital on 11th October 2014 for rehabilitation. He developed small moister lesions on his bottom which were referred to tissue viability nurses and treated. He was eating and drinking well and his weight was stable. He transferred to Daisy Bank Nursing Home Cheadle on 22nd November 2014. The home's management team were often absent and communication between management and staff proved difficult. Financial difficulties resulted in staff, equipment, food and other essential supply shortages. Clear protocols and polices were not in place. The deceased developed serious pressure sores. No contact was made with tissue viability nurses until 15th December 2014. Advice to upgrade his mattress was not followed. There was confusion with regards to further referrals to the tissue viability nurses and a second referral was not made until 5th January 2015. Records were not fully maintained and there were gaps in turning charts. The deceased was sometimes noted to be non-compliant with his medication and care regime. He lost over 3 stone in weight during his 7 week stay. There was no referral to district nurses, dietician or mental health services. The involvement of the general practitioner was minimal. Blood tests revealed a raised erythrocyte sedimentation rate indicating possible infection but no treatment was prescribed and there was no further investigation. Tissue viability nurses attended on him on 7th January 2015. He was found to be in pain. He had infected pressure sores, contracted limbs and significant weight loss. He was readmitted to Leek Moorland Hospital on 8th January 2015 and found to have extensive multiple pressure sores and dehydration. He was transferred to Abbey Court Nursing Home, Buxton Road, Leek on 3rd February 2015 and died there on 14th February 2015. |



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 home known as Daisy Bank Cheadle has now closed however there are three other care homes which remain under that same ownership of and managed by the same Chief Executive, Mr Tee.
(2) Poor management and absences of management staff was evident during the inquest. The home manager was not registered and was not medically qualified.
(3) Financial difficulties led to shortage of staff, food and other equipment.
(4) There were no clear policies and procedures in place.
(5) Mr Beard's deteriorating pressure ulcers were not referred to the Tissue Viability Nurses in a timely fashion and advice, once given, was not followed. Turning charts were not filled in and an upgraded mattress was not provided.
(6) Mr Beard lost a significant amount of weight. There was no referral to a dietician, physiotherapist, mental health services or involvement of District Nursing Teams.
(7) The involvement of the GP was minimal and there was no follow up when blood tests revealed an abnormality.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you or 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 Wednesday 30th November 2016. I, the assistant 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. (daughter of the deceased)
2. (daughter of the deceased)
3. , BLM Law
4. CQC
5. Adult Safeguarding
6. , Staffordshire & Stoke-On-Trent NHS Partnership Trust
7. Staffordshire Police
8. , GP
9. nurse
10. nurse
11. nurse
12. Care home owner
13. Nursing & Midwifery Council.

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 Signature: M. J. Jones

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