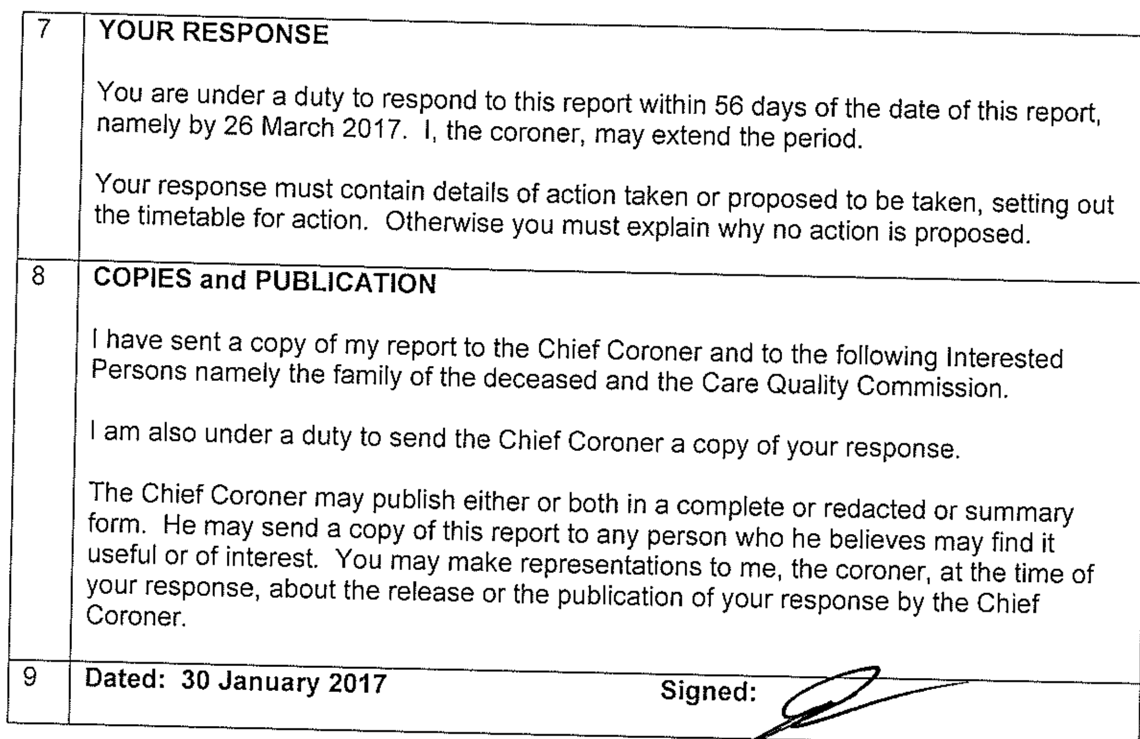
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. St Helens Clinical Commissioning Group 2. Halton Clinical Commissioning Group
1	**CORONER** I am Janet Elizabeth Napier, assistant coroner, for the coroner area of Cheshire
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 7 April 2016 an investigation was commenced into the death of Frederick Chisnall aged 79 of Forshaw Unit, St Mary's Nursing Home, Penny Lane, Warrington. The investigation concluded at the end of the inquest on 19 December 2016. The conclusion of the inquest was that the deceased died due to a myocardial infarction.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was subject to a Deprivation of Liberty Order at the time and was being given one to one nursing care, which I was told was commissioned by yourselves, from the two Agencies "Reflex" and "Challenge Recruitment". I believe an Adult Safeguarding investigation was carried out following the death and was not finalised by the date of the inquest.
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. During the inquest concerns were raised about the actions of the Agency staff regarding producing proper documentation, and being aware of how to monitor changes in clinical condition and obtaining medical or nursing help urgently when appropriate. Although in this case this did not cause any serious sequelae, I wonder if you could assess the adequacy of the training given to the staff you commission, to ensure this does not happen in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 26 March 2017. 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 the family of the deceased and the 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	**Dated: 30 January 2017** **Signed:**