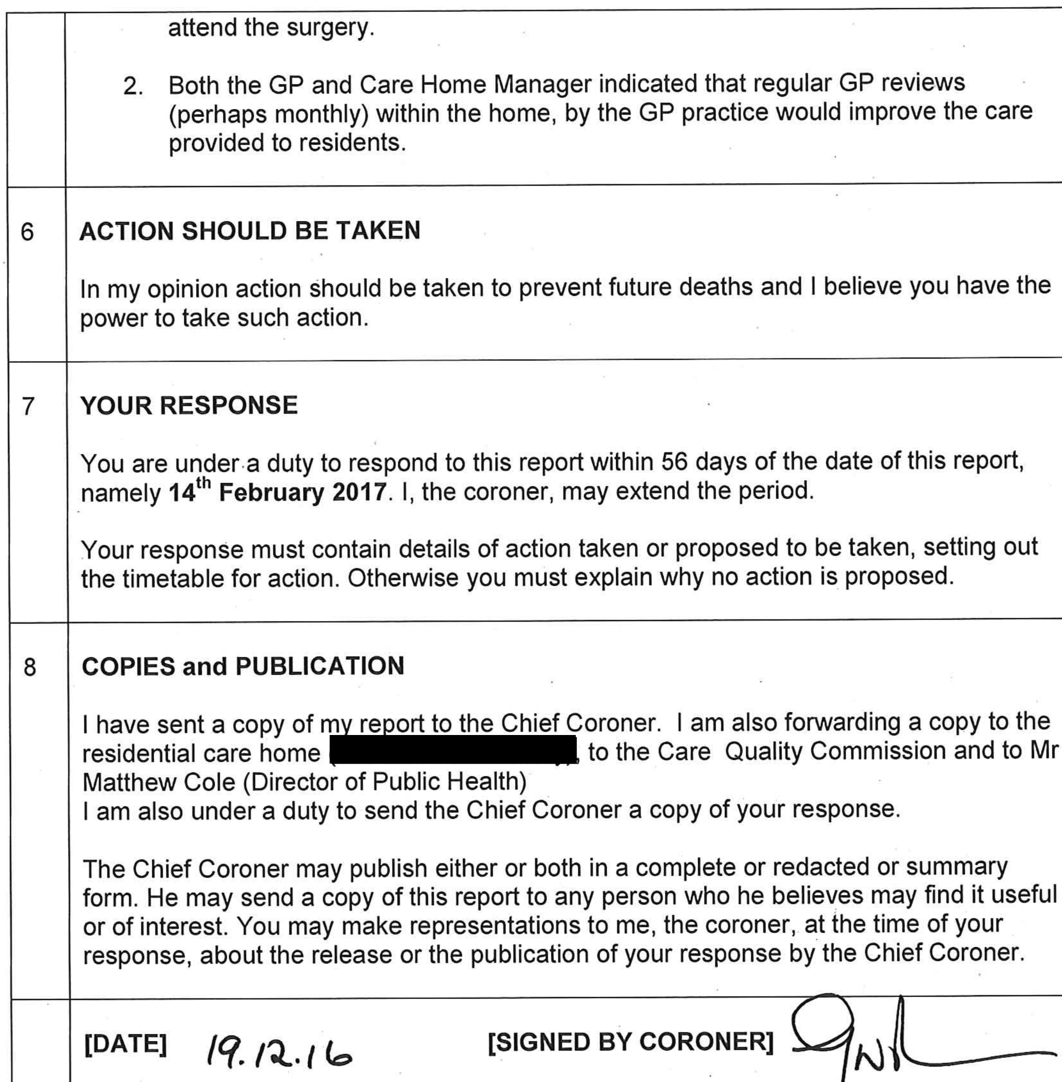
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [REDACTED] **General Practitioner, Lime Tree Surgery, 321 High Road, Leytonstone, London, E11 4JT**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Coroner area of East 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 31st May 2016 I commenced an investigation into the death of Mr Terence Hawkins. The investigation concluded at the end of the Inquest on the 16th December 2016. The conclusion of the Inquest was that Mr Hawkins died from natural causes.
	CIRCUMSTANCES OF THE DEATH Mr Hawkins was an 88 year old gentleman. He had been admitted to St. Catherine's Residential Care Home in 2010 and registered with the Lime Tree surgery in June 2010. He had a background medical history of dementia, alcohol abuse, osteoporosis and recurrent falls. He had also developed swallowing difficulties. He was cared for at St. Catherine's Residential Care Home under a Deprivation of Liberty Safeguarding authorisation. In March 2016 the care home requested a GP visit due to increased frailty and loss of weight. A routine GP visit should have taken place, but did not. During the early hours of the 12th May 2016, Mr Hawkins was found to be vomiting in his bed. The care assistant was in the course of changing his clothing and bedding when he noted Mr Hawkins had become unresponsive. The London Ambulance Service were called and CPR was commenced. It was later discovered that a DNAR order had been in place. Upon arrival of the paramedics it was clear that Mr Hawkins was deceased and life was pronounced extinct at 05:12 on the 12th May 2016. A forensic post-mortem was carried out which confirmed a cause of death of 1a: Congestive heart failure, 1b: Ischaemic heart disease and 2: Alzheimer's disease.
5	**<u>CORONER'S CONCERNS</u>** The **MATTERS OF CONCERN** are as follows. – 1. There was no system in place for the regular medical monitoring of residents with the Care Home. Mr Hawkins had not been seen by a GP for many months. The Care Home Manager confirmed that it could be difficult for medical assessments to be arranged for residents within the home who are unable to



	attend the surgery. 2. Both the GP and Care Home Manager indicated that regular GP reviews (perhaps monthly) within the home, by the GP practice would improve the care provided to residents.
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 **14th February 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. I am also forwarding a copy to the residential care home , to the Care Quality Commission and to Mr Matthew Cole (Director of Public Health) 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.
	[DATE] 19.12.16 **[SIGNED BY CORONER]**