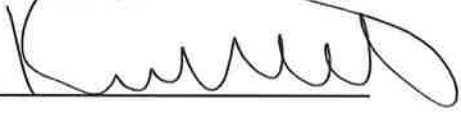




H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Care UK Head Office, Connaught House, 850 The Crescent, Colchester Business Park, Colchester, Essex CO4 9QB
1	CORONER I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 the 1/3/2016 I commenced an investigation into the death of Daphne Cherry. The investigation concluded at the end of the inquest on the 9 th March 2017. The conclusion of the inquest was a narrative conclusion. The medical cause of death was 1A bronchopneumonia and 2 gastric erosions and bladder cancer.
4	CIRCUMSTANCES OF THE DEATH Daphne Cherry was an 83 year old lady with a significant medical history including diabetes, hypertension and dementia. She had been a resident at a Care Home in Cheltenham since February 2015. At the beginning of February 2016 she had suffered an episode of diarrhoea and vomiting. Thereafter her appetite decreased. On the 17 th February she was diagnosed with a urinary tract infection, and her GP prescribed antibiotics. That prescription was further extended on the 19 th . Over the weekend of the 20 th and 21 st February 2016, staff at the care home were aware that Daphne was suffering an infection, taking antibiotics, and that her fluid intake was lower than her recommended level. Staff and family members were encouraging her to take sips of water. However when her fluid intake continued to decline staff did not escalate the matter, and no medical review was sought until after 6am on Monday 22 nd February. Paramedics attended, and Daphne was transferred to hospital where a severe kidney injury was diagnosed. She was severely dehydrated, and appropriate treatments were instigated. Daphne's condition steadily deteriorated and she passed away at 23.15 hours on the 22 nd February 2016. The post mortem has identified a natural cause, bronchopneumonia as the final factor that caused Daphne's death, in the context of gastric erosions and bladder cancer. The likelihood of Daphne developing bronchopneumonia was increased due to her age, the fact that she had developed an infection, and that she had sustained an injury to her kidneys. There are several possible causes for the latter injury including a lack of fluids, an infection, and the medications Daphne was taking.
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) Whether staff at the Care Home are able to identify when a medical concern should be escalated and a medical review sought.

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm 8th May 2017. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <ul style="list-style-type: none"> (1) [REDACTED] Manager of Sandfields Care Home, St George's Road, Cheltenham, Gloucestershire, GL50 3DU (2) Barlow Robbins Solicitors for the family, [REDACTED] The Oriel, Sydenham Road, Guildford, Surrey GU1 3SR, (3) Care Quality Commission, CQCInquestsandCoroners1@cqc.org.uk and 151 Buckingham Palace Road, London, SW1W 9SZ. <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 13th March 2017</p> <p>Signature </p> <p>Ms K Skerrett Senior Coroner for Gloucestershire</p>