



H M Assistant Coroner for Gloucestershire
Dr Simon Fox QC

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| | <p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: The Grange Care Centre, Leckhampton, Cheltenham, Gloucestershire, GL53 9ER, C/o [REDACTED] DAC Beachcroft Claims Ltd, 100 Fetter Lane, London EC4A 1BN</p> |
| 1 | <p>CORONER</p> <p>I am Dr Simon Fox QC, Assistant Coroner for Gloucestershire.</p> |
| 2 | <p>CORONER'S LEGAL POWERS</p> <p>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.</p> |
| 3 | <p>INVESTIGATION and INQUEST</p> <p>On the 5.4.16 I commenced an investigation into the death of Terence James White. The investigation concluded at the end of the inquest on 14.3.2017. The conclusion of the inquest was natural causes. The medical cause of death was 1a Sepsis and Hypertensive Cardiac Failure 1b Infected Sacral Pressure Sore.</p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr White died in part from infection from a grade 4 sacral pressure sore which developed at The Grange Care Centre between January and March 2016.</p> |
| 5 | <p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>The Care Centre records documented the presence of the pressure sore appropriately but there was a very substantial absence of documentation recording measures in place to treat the pressure sore and in particular a very substantial absence of turning charts making it impossible for Senior Staff to know if the condition was being treated properly.</p> |
| 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 on 4th 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> |

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| 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) Family – Son in Law, [REDACTED](2) [REDACTED] - Glos. NHS Trust, Cheltenham General Hospital, Sandford Road, Cheltenham, GL53 7AN(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 16 March 2017</p> <p>Signature <u>Simon Fox</u></p> <p>Dr Simon Fox QC Assistant Coroner for Gloucestershire</p> |