REGULATION 28: REPORT TO PREVENT FUTURE DEATHS .

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Coroner 2. Quality Care Commission 3. Care Agency – Unique Care Services 4. [redacted] – Daughter of Deceased
	CORONER I am Mrs Jean Harkin, Assistant Coroner for the coroner area of County 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	INQUEST Date:- Friday 27th July 2017 Name of Deceased:- Maureen Ann Colclough Date of Birth:- 16th July 1955 Date of Death:- 16th December 2016
4	CIRCUMSTANCES OF THE DEATH On the 16th December 2016 he deceased was found unresponsive at home by two carers from Unique Care Services at 1600 hours on 16th December 2016. The deceased was breathing heavily and her eyes were flickering, the carers were unable to rouse her despite sitting her up higher in bed and shouting her name. The carers telephoned their care manager who agreed that the deceased be left asleep as she was breathing. The carers presumed she had been drinking alcohol and that was why she would not wake up. The carers then left the property at approximately 16.15 Hours. The Deceased's daughter returned home from work at 17.25 hours and on finding her mother unresponsive called 999. Sadly paramedics confirmed her deceased at 17.41 hours. The deceased had recently completed a 12 week alcohol reduction programme and there was no evidence presented in court by police or other witnesses that there was alcohol abuse by the deceased. No bottles or glasses were found near or around the deceased. The evidence of fact was that the deceased was likely in a comatose state and that earlier intervention could have saved her. The deceased was taking opiates for pain and had alcoholic fatty liver disease along with other co morbidities. It emerge that the carers remained of the opinion that they acted accordingly. The care manager, after hearing evidence in court, confirmed that had she known the detail she would have advised calling the emergency services rather than leaving the deceased alone.

	An advanced nurse practitioner gave evidence that the deceased was likely in a comatose state that could have been reversed with appropriate medical intervention. Evidence in court also confirmed the fact that the carers had lifted the deceased into a higher position on the bed, this did not awaken the deceased.
5	**CORONER'S CONCERNS** 1. Inadequate training of staff to recognise emergency situation. 2. Relying on presumptions when finding an unresponsive patient in a serious situation.
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 21st September 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** Copies to: 1. **Chief Coroner** 2. **Quality Care Commission** 3. **Care Agency – Unique Care Services** 4. [redacted] **– Daughter of Deceased** 5. **End copy record of Inquest**
9	DATE **27th July 2017** SIGNED BY CORONER **(Mrs Jean Harkin)**