REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Managing Director Sunrise Senior Living Ltd.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester.
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 7th March 2014 I commenced an investigation into the death of **RHYS TUDOR WILLIAMS** dob 29TH APRIL 1927. The investigation concluded on the 3RD DECEMBER 2014 and the conclusion was one of **ACCIDENTAL DEATH AGGRAVATED BY NEGLECT**. The medical cause of death was (1a) ISCHAEMIC HEART DISEASE AND ATRIAL FIBRILLATION. (11.) ALZHEIMER'S DISEASE.
4	**CIRCUMSTANCES OF THE DEATH** **On the 3rd March 2014 at Sunrise Senior Living, 1 Dairy Ground Road, Bramhall, Stockport, Dr Williams was put to bed by Carers at approximately 8.00pm. At 1.40 am he was found, deceased, between his bed and the wall. The brakes to his bed had not been applied and there was a crash mat and a sensor mat on one side of his bed only.**
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. There appeared to be a lack of training (in a number of areas) of the carers having immediate care of Dr Williams. I was told that they should all undertake e-learning but it was far from clear as to how (or whether) this was monitored and checked.** **2. Despite the assurances of the Managing Director, who was very frank and helpful in her evidence, I remained far from satisfied that all the staff members were aware of the rules relating to the positioning of the 'profile beds' which are on caster wheels. Because of this lack of certainty amongst the staff members, Dr Williams' bed was placed, allegedly, against the wall when apparently this should not have been the case. Are all the staff members now clear as to the Rules relating to the positioning of the profile beds? Is there a rule about the need for crash mats and sensor mats on both sides of the bed?**

	3. **I was told about the way in which Care Establishments must now assess their clientele and based on that assessment, they should determine how many staff members are required at any time. I remain unconvinced that a proper assessment had taken place but in any event I was told that the night staff members had to perform additional tasks of cleaning and laundry. Has this assessment of the number of staff and the additional duties to be undertaken by them, been addressed?** 4. **During the course of the evidence it became apparent that public money was being sent to Sunrise Senior Living for the provision of nursing care for Dr Williams. Whilst I accept that a nurse was present on site albeit in the other part of the Home, this was accepted by the Managing Director as not amounting to the provision of nursing care. The payment was apparently 'credited' against the account of Dr Williams, but I am concerned that as a result of this apparently flawed system, he was not in fact allocated to the correct type of care. Has this system now been reviewed and any change brought about?** 5. **The requirement for bed brakes to be properly applied when the staff members are not in the room should be an absolute requirement and this should be reinforced in writing to all staff.** 6. **There was an apparent failure by the staff (notably the managers who changed on a number of occasions) to pass relevant information to their successors, and the daughter of Dr Williams had to reiterate the same information several times. This led to a lack of confidence by the family of the deceased that his care needs were properly being made known to those having care of him.** 7. **Following on from 6 above, the system for providing relevant information to the relatives was flawed as the necessary files were archived and inaccessible. Has this been changed or is it intended that it should so be? This is relevant to future deaths, because it may hamper the ability to ensure that the patient is receiving optimum care in the most appropriate establishment.** 8. **Care notes were completed for the full period of the night shift of the 3rd to the 4th March 2014, at the beginning of that shift, i.e. before the visits had actually taken place. This was clearly unacceptable. Has anything been put in place to prevent this happening in the future?** 9. **Some members of staff were clearly under the impression that they should not call an ambulance but should contact the nurse on site who would then do so. This could lead to unacceptable delays in the attendance of potentially life-saving emergency services. Has this misapprehension been addressed?**
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 by **9th February 2015**. 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 [redacted] **(son-in-law and daughter of Dr Williams) and Stockport MBC Environmental Health Officers**. I have also sent it to The Care Quality Commission who may find it useful or of interest. 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	**15.12.14** **John Pollard, HM Senior Coroner**