Raymond Frederick Curtis
Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Company Secretary, Beech Cliffe Limited of Beech Cliffe Grange Care Home, Munsborough Lane Rotherham S61 4NS**
1	**CORONER** I am Raymond Frederick Curtis, Assistant Coroner for South Yorkshire (East District)
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 03/03/2016 I commenced an investigation into the death of Steven Jones, 27. The investigation concluded at the end of the inquest on 14 November 2017. The conclusion of the inquest was a narrative conclusion of: natural causes in circumstances where it is unclear whether any deficiencies in care and or delays in seeking further medical advice contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** Steven Jones, a young man aged 27 years at the date of his death had serious learning difficulties, was in the autism spectrum and was non-verbal. He was a resident at Beech Cliffe Grange Care Home, Rotherham where he was generally well cared for. He became ill on the 21st November 2013 with symptoms of sickness and diahorreah, loss of appetite and sleeping disorder, some of which were manifest at various times until his death on 10th December 2013. One of the registered managers consulted his general practitioner on 28th November 2013 in his absence. Handover sheets were reasonably well completed by carers between 21st November 2013 and 8th December 2013 but concerns were not always emphasised, incident reports were never raised, and the quality and nature of verbal communication to senior staff and managers was not clear. Despite a brief period of improvement after 28th November 2013 his condition deteriorated and he vomited faecal matter on the 8th December 2013. He was admitted to Rotherham General Hospital on that day where a CT scan confirmed by surgery on the 9th December resulted in a diagnosis of a perforated colon leading to multi-organ failure and his ultimate demise. He died on the 10th December 2013 and an Assistant Coroner accepted the medical cause of death as follows: 1a. multi-organ failure and hypoxic brain injury 1b. cardiac arrest 1c. spontaneous perforation of sigmoid colon (operated) 2. severe autism before issuing the appropriate documentation. Anonymous letters raised several matters and after they were referred to the Coroner by the police an investigation was opened on the 3rd March 2016.

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) Although a system of written recording was in place, concerns of carers were not emphasised nor escalated to seniors either through incident reports or verbally so that opportunities to initiate full investigations by seniors and/or managers were lost. (2) Staff did not appreciate the importance of incident reports and that such reports encompassed illness. (3) In practice staff did not act directly in dealing with illness of a resident, rather channelling medical issues through the registered managers. (4) On the occasion of a serious incident of faecal vomit, staff did not assume responsibility for calling emergency services but telephoned the registered managers who in turn did not appreciate the seriousness of the situation resulting in a delay in transferring the resident to hospital. (5) In the case of a non-verbal resident with serious problems very early referral to a general practitioner was not made and when made the resident was not present at the consultation nor was his one to one carer in attendance.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you the Company Secretary of Beech Cliffe Limited 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 the **09 January 2018.** 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: Messrs Beachcroft Solicitors, Rotherham MBC Safeguarding, Messrs Switalskis Solictors, [redacted] of the MPS & Messrs Capsticks solicitors. I have also sent it to the CQC 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	Dated 14 November 2017 Signature_____ Assistant Coroner for South Yorkshire (East District)