REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Mr Andrew Frederick Worsley, Director, Harbour Healthcare Ltd, Lodge House, Dodge Hill, Stockport, SK4 1RD
1	**CORONER** I am, Chris Morris, Area 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 9th November 2017, I opened an Inquest into the death of Joan Lunt, who was aged 90 when her death was confirmed at Stepping Hill Hospital, Stockport on 27th October 2017. The investigation concluded at the end of the Inquest which I heard on 22nd May 2018. The conclusion of the Inquest was that Mrs Lunt died as a consequence of **Natural Causes.**
4	**CIRCUMSTANCES OF THE DEATH** Mrs Lunt had a complex medical history which included idiopathic pulmonary fibrosis. In April 2017, Mrs Lunt moved into Hilltop Hall Nursing Home in Stockport. By this time in her life, Mrs Lunt had been prescribed oxygen to be administered via nasal cannula for 16 hours every 24 hour period. On 26th October 2017, Mrs Lunt became unwell and a GP was called. Suspecting she was suffering from a chest infection, the GP prescribed antibiotics and gave advice as regards nutrition and hydration, and administration of additional oxygen. Overnight at around 01:00, Mrs Lunt was found to be seriously unwell. An ambulance was called, whose crew provided advanced life support and transferred her to hospital once stabilised. There, it was confirmed that Mrs Lunt had sadly died. A post mortem examination ascertained that the medical cause of Mrs Lunt's death was: 1a) Acute myocardial ischaemia; b) Coronary atherosclerosis and Hypertensive heart disease; II) Idiopathic pulmonary fibrosis with bronchopneumonia

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. – In the course of evidence heard at the inquest, it emerged that there were significant deficiencies in the way in which agency care staff recorded information about residents on Hilltop Hall's electronic records system. The evidence before the court was that agency staff would either: 1. Relay matters to be recorded in the notes to a substantive member of staff who would then make an entry reflecting what they had been told (i.e. in the name of the substantive staff member in question); or 2. Make an entry directly on the system which simply records it has been made by 'Agency Staff', rather than explaining the identity and role of the person making the record. This issue raises significant concerns about the integrity of Hilltop's electronic patient record, particularly as far as it relates to checks made on vulnerable residents by care staff. In addition to making it difficult or impossible in retrospect to identify which member of staff has undertaken what activity, the current system has the potential to lead to miscommunication between staff members (for example, in relation to which staff member on a shift has undertaken important checks on residents' wellbeing), and can be detrimental to continuity of care. A further matter of concern which emerged in evidence from the Team Manager from Stockport Metropolitan Borough Council's Adult Safeguarding service is that this issue has apparently been raised previously by the local authority in the context of another safeguarding investigation. The Team Manager's evidence was that assurances had been received from managers at Hilltop Hall that this issue had been addressed, whereas Mrs Lunt's records suggest this is not, in fact, the case.
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 24th July 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 namely [redacted] son of the deceased, 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	**Chris Morris** **HM Area Coroner** **29/05/2018**