	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: [redacted] **Brancaster Care** **Genesis Centre** **Birchwood** **Warrington** **WA3 7BH**
1	**CORONER** I am David Urpeth, assistant coroner, for the coroner area of South Yorkshire West
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 25.1.18, an investigation into the death of John Duckenfield was commenced. The investigation concluded at the end of the inquest on 13.12.18. The conclusion of the inquest was a narrative conclusion, copy attached.
4	**CIRCUMSTANCES OF THE DEATH** Mr Duckenfield was in Pexton Grange for intermediate care following a fall. He was in Pexton Grange between 12.12.17 and 2.1.18. Between 29.12.17 and 2.1.18, he was seen by a GP on two occasions and treated for a chest infection. He was admitted to Northern General Hospital on 2.1.18, where he remained until his death on 21.1.18.
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. – During the inquest, evidence showed:- 1. [redacted] falsely asserted he had taken observations of Mr Duckenfield in the presence of the family. Not only I, but safeguarding also, felt this assertion was dishonest. 2. He failed to record observations he said he carried out despite accepting a need to do so. 3. Falsely asserted he was never asked to call a GP 4. The care home manager, [redacted] said observations should have been taken daily and recorded but were not. Surprisingly therefore, she, asserted the care rendered was reasonable. 5. Records kept by he home were inaccurate and misleading.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 6th March 2019. 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 to all Interested Persons :- The family of Mr Duckenfield, the deceased. Sheffield City Council CQC Shiregreen Medical Centre 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	**18.12.18** **SIGNED BY DAVID URPETH ASSISTANT CORONER**