**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO: Care Quality Commission, Registered Manager of Serendipity Care Home, Chief Executive of Lancs & Cumbria Lifts UK Ltd, Chief Executive of Health and Safety Executive, Secretary of State for Work and Pensions |
| 1 | CORONER<br><br>I am Alison Mutch, Senior Coroner, for the Coroner area of South Manchester |
| 2 | CORONER'S LEGAL POWERS<br><br>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<br><br>On 1st February 2017 I commenced an investigation into the death of Kenneth Roy Bardsley. The jury inquest concluded on the 26th November 2018 and the conclusion of the jury was one of **Accidental death contributed to by failure of interior door mechanism.**<br><br>The medical cause of death was **1a) Multiple injuries; 2) Osteoporosis; Ischaemic heart disease; Valvular heart disease** |
| 4 | Mr Kenneth Roy Bardsley died on the 30th January 2017, at Salford Royal Hospital due to multiple injuries, received as a passenger in a lift, which malfunctioned at Serendipity Care Home. |
| 5 | <u>CORONER'S CONCERNS</u><br><br>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.<br><br>The MATTERS OF CONCERN are as follows. – |

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| | 1. The inquest heard that there are no formal requirements for a minimum standard of qualification for people to be lift engineers. In effect, anyone can advertise themselves as a lift engineer/maintenance company;<br>2. The evidence given to the inquest was that there was a gap in the system which meant that regulatory lift examinations could take place but not be read or acted upon, with no escalation process;<br>3. During the inquest evidence was given that within the specific lift company in this case and more widely, there was a lack of clarity as to how engineers should be made aware and follow up requirements made by engineers carrying out the regulatory lift examinations;<br>4. In inspections of the home, the CQC did not pick up that there were faults identified in the regulatory examination that had not been acted upon;<br>5. That Serendipity Care Home did not have a system in place to ensure details from the lift examinations were read; considered and passed on to the lift servicing company;<br>6. That the lift company Lancs and Cumbria engineers carrying out serving/repairs were not expected to ask to see the regulatory examination reports;<br>7. That the lift company Lancs and Cumbria Lifts had abandoned their old paper checklists and introduced an electronic appointment system. However that system did not include an electronic checklist. One had now been introduced. It was unclear if other companies have checklists and if so how consistent are they. The inquest heard that there was no statutory minimum expectation about the requirements of a lift service. |
| 6 | ACTION SHOULD BE TAKEN<br><br>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<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th February 2019. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be |

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| | taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. |
| 8 | COPIES and PUBLICATION<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely 1) [redacted], son of the deceased; 2) [redacted] 3) Bureau Veritas Ltd, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **Alison Mutch OBE**<br>**HM Senior Coroner**<br>**27.12.2018** |