REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **(grand-daughter)** 2. **Chief Coroner** 3. **Care Quality Commission** 4. **Regional Manager, Rossmere Park Care Home**
1	**CORONER** I am Clare Bailey, senior coroner, for the coroner area of Teesside and Hartlepool
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 5 October 2018 I commenced an investigation into the death of Gloria Elizabeth MEKINS, aged 72 years. The investigation concluded at the end of the inquest on 17 May 2019. The conclusion of the inquest was ACCIDENT and the medical cause of death was Ia) Asphyxia due to Ib) Laryngeal Obstruction due to Bolus of Food.
4	**CIRCUMSTANCES OF THE DEATH** Ms Mekins was a resident at Rossmere Park Care Home in Hartlepool. On 2 October 2018 at approximately 14:30 hours she was sat in an armchair in her room eating a snack, dairylea lunchables. At approximately 14:40 hours staff attended and believed she was choking. Assistance was sought from staff members. However, evidence was given at the Inquest which raised concerns of the Coroner. She died at the Care Home on 2 October 2018.
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) The Health Care Assistant who initially discovered Ms Mekins choking carried out no first aid, nor did she take any action to try to clear Ms Mekins' mouth or help improve her breathing, eg back slaps or Heimlich manoeuvre. (2) There was confusion as to the existence of a DNA CPR and this led to a delay in the provision of first aid. (3) The Care Home had not undertaken an internal investigation into events surrounding Ms Mekins' death and have not identified the above issues, nor have they attempted to remedy them. The Senior Coroner is concerned that the above issues place residents at the Care Home at risk of serious injury or death.

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 23 July 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 and to the following Interested Persons, Care Quality Commission. I have also sent it to [redacted] (grand-daughter) 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	**28 May 2019** **[SIGNED BY CORONER]**