REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, HC-One, Southgate House, Archer Street, Darlington, DL3 6AH c/o Dovetail Court Care Home** **2. Managing Director, Lakeview Care Home** **3. Care Quality Commission are copied in for their reference only.**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 16 November 2018, I commenced an investigation into the death of Mrs Margaret Melia. The investigation concluded at the end of the inquest on 1 April 2019. The conclusion of the inquest was a short form conclusion of natural causes. The cause of death was: 1a **Advanced Dementia** b **c** II **Old Age, Malnourished, Ischaemic Heart Disease**
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Melia was admitted to Dovetail Court Care Home on the 9 October 2018 from Lakeview Care Home. She had a medical history including arthritis, Alzheimer's, chronic obstructive pulmonary disease and required substantial care for her daily living activities. ii) As part of the pre-assessment, on the 29 September 2018, Mrs Melia was assessed by a manager from Dovedale Court. The nurse on duty (Lakeview Care Home) advised the assessor that she would be requesting the GP to visit her in 2 days (01.10.18) to prescribe subcutaneous fluids due to Mrs Melia's oral intake was poor and it would be required if her fluid intake dropped below 500ml daily. iii) The relevant equipment required to administer subcutaneous fluids wasn't available at Dovetail Care Home and no subcutaneous fluids were given. iv) Mrs Melia's condition started to decline rapidly from around the 22 October

	and her food and fluid intake dropped. v) She was admitted to Sandwell Hospital and treated for dehydration and a lower respiratory tract infection with antibiotics. Sadly, her condition continued to decline and she was placed on end of life palliative care. She passed away on the 7 November 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. Evidence emerged during the inquest that there was an inadequate discharge and pre-assessment process between Lakeview Care Home and Dovetail Care Home over the requirement of subcutaneous fluids.
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. 1. Both Care Homes may wish to consider urgently reviewing the protocols in place during discharge and pre-assessment of patients. In particular, the requirement of any medication should be set out clearly to avoid any misunderstanding that could result in harm to a patient.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 June 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; Family. 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 April 2019** **Mr Zafar Siddique** **Senior Coroner**

	Black Country Area