REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Regional Manager, Rosewood Healthcare Group, Asher House, Suite A, Barsbank Lane, Lymm, Cheshire, WA13 0ED 2. [redacted] PMMD, Wigan Life Centre (South Suite), College Avenue, Wigan, WN1 INJ 3. Ian Trenholm, Chief Executive, Care Quality Commission, Care Quality Commission, Citygate, Gallowgate, Newcastle upon Tyne NE1 4PA
1	**CORONER** I am Rachel Syed, HM Assistant Coroner for the Coroner Area of Manchester 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 the 26th March 2019, I commenced an Investigation into the death of Sidney Clarence Baker, born on the 23rd June 1928. The Investigation concluded at the end of the Inquest on the 20th November 2019. The medical cause of death was: - Ia Bronchopneumonia II. Ischaemic Heart Disease, Cerebrovascular Disease, Lower Urinary Tract Infection The Inquest conclusion was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Clarence Baker died on 24th March at the Royal Albert Edward Infirmary in Wigan. The circumstances of his death are as follows, Mr Baker was a frail elderly gentleman, who suffered from a number of co-morbidities, including Dementia, Chronic Kidney Disease, Type II Diabetes, Osteoporosis, previous bladder cancer and aortic aneurysms. As a consequence of Mr Baker's poor health, it was deemed necessary to admit him to a specialist care facility in 2014. By December 2018, a decision was made to transfer Mr Baker's care to a nursing facility and he was assessed and secured a placement at Barley Brook

	care home on or around 23rd January 2019. During January to March 2019, Mr Baker had a number of unwitnessed falls, but did not sustain and physical injuries. A falls team referral should have been made by March 2019, but this did not occur. Mr Baker also struggled to eat and drink during this period which should have warranted a dietician's referral but once again, one was not made. Due to Mr Baker's declining health, his GP surgery was contacted on or around 11th March 2019, regarding concerns about his general frailty, weight loss and Do Not Attempt Resuscitation. The surgery saw Mr Baker on 12 March 2019 and following an examination, diagnosed him as having a general deterioration in his health. Safety net advice was given and Mr Baker was then taken to hospital on 13th March 2019 following a fall at his care home. At hospital he was diagnosed and treated for acute kidney injury but his condition deteriorated and he died on the above date.
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 was heard that: - 1. There were no contemporaneous documents that a Dieticians or Falls Team referral had been made by the Care Home personnel in question 2. There were concerns that entries contained in Mr Baker's care plan were incorrect, including vital information contained on his weight monitoring sheet. Furthermore, the general quality of record keeping was poor. I request that you undertake a review to ensure staff receive the appropriate training on the issues identified above.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 **27th January 2020**. 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:- 1. [redacted] - Bereaved family

	2. CQC 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	**Dated** **02 December 2019**	**Signed** **Rachel Syed** **HM Assistant Coroner**