REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: (1) Hurst Hall Care Centre, Kings Road, Ashton under Lyne OL6 9EG** **(2) GTD Healthcare**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 17th February 2015 I commenced an investigation into the death of **Elsie Clarke** dob 28th October 1921. The investigation concluded on the 16th July 2015 and the conclusion was one of **a narrative conclusion**. The medical cause of death was 1a Bronchopneumonia.
4	**CIRCUMSTANCES OF THE DEATH** **Mrs Clarke was resident at Hurst hall care Centre and from the morning of 10th February 2015 she was developing a significant and ultimately catastrophic pneumonia: Opportunities were missed during the day to summon medical help, which if called earlier might have led to a different outcome. She died later that day.**
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) There was an apparent lack of training for the staff at Hurst Hall in the appropriate use of calling either 999 or 111.** **(2) The staff did not know how to arrange for the attendance of a GP for a resident who was not yet fully registered with a local GP. In particular they appeared completely ignorant of the existence of a "Temporary GP Registration form".** **(3) The level and quality of observation of the residents were very poor and did not include even some of the most basic issues such as whether the patient was warm, thirsty etc.** **(4) There seemed to be a complete lack of understanding about the legal requirement for prompt reporting of such matters as occurred in this case to the Care Quality Commission.**

	(5) When a local GP was visiting another patient at the Home, the staff seemed unaware that they could and should have asked that doctor to look at this patient/resident. **(6) There was a complete failure to maintain food and hydration records.** **(7) There was a failure to keep proper and sufficient notes of the care afforded to each resident.** **(8) There was a failure to give full and effective "hand-over" at each shift change.** (Numbers 1 to 8 above to be answered by Hurst Hall) **(9) There was an obvious gap in the training of Out of Hours doctors in a number of aspects including (a) Keeping proper timed records of each attendance on a patient (b) Wearing or carrying a watch so as to be able to assess pulse rates, respiration rates etc. (c) Process for reporting deaths as necessary to the Coroner** **(10) The doctor advised the Home that in the present case there was no need to call the Coroner/police** (numbers 9 and 10 to be answered by GTD Healthcare)
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **14th October 2015** . 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 namely [redacted] (son of the deceased). I have also sent it to **The Care Quality Commission, to Eastlands Medical Practice and to Bedford House Medical Centre** 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	**20.8.15** **John Pollard, HM Senior Coroner**