REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **This report is being sent to:** Crown Care 15/16 Stockholm Close Tyne Tunnel Trading Estate **Tyne & Wear** NE29 7SF
1	**CORONER** Abigail Combes
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** In September 2019 I commenced an investigation into the death of Eileen Pollard. The investigation concluded following an inquest on 28 February 2020 where the conclusion was: • Natural Causes On 19 February 2019 Eileen Pollard died at hospital following a deterioration of her health conditions whilst resident in Buckingham Care Home, Penistone.
4	**CIRCUMSTANCES OF THE DEATH** Overnight on 27-28 March 2019, Eileen Pollard, who was resident at Buckingham Care Home for respite care, became unwell with the symptoms of a myocardial infarction. She was taken to hospital by ambulance on 29 March 2019 where she passed away two days after her admission. During the course of her admission Eileen Pollard raised concerns about the fact that she had been pressing her nurse call bell which was not answered or was not working. The medical evidence presented at inquest was clear that even if this was the case, the outcome for Eileen Pollard would not have been any different.
5	**CORONER'S CONCERN** During the course of the investigation my inquiries revealed matters giving rise to a 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 – a) The call bells are checked daily as part of routine maintenance however the document which records the checks is pre populated with a 'P' for pass. This could lead to rooms being missed in the checks or a failure to correct a 'P' to an 'F' in the event of a fail. It may be the case that in the event of another patient requiring a call bell and it not working this could make a significant difference to the outcome for that individual and for that reason the maintenance arrangements are important.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the named organisation have the power to take such action. I request that the organisation look again at the forms and documentation used to check call bells and reconsider whether these should be pre populated or blank to be completed contemporaneously with the check.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 April 2020. I may extend this period upon request. 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 family of the deceased and to the Chief Coroner. 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	**Abigail Combes** **3rd March 2020**