Regulation 28: Prevention of Future Deaths report

Joseph O'NEILL (died 12.08.20)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Managing Director** **Care Outlook Limited** **260 Stanstead Road** **Sydenham** **London SE23 1DD**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 20 August 2020, I commenced an investigation into the death of Joseph O'Neill, aged 88 years. The investigation concluded at the end of the inquest earlier today. I made a narrative determination, a copy of which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Mr O'Neill developed bronchopneumonia, suffered heat stroke, then became dehydrated and died. If he had been properly hydrated and had been in an appropriately cool environment, he would not have died when he did.

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. Mr O'Neill was attended by carers from Care Outlook four times a day. It was noted that he was very hot and he was brought a fan. He was also offered respite care in a care home. However, he was fearful of catching COVID19 and in 2020 care home COVID death rates were very high. When Mr O'Neill refused a place in a care home, the Care Outlook staff did not do anything to resolve the fault with Mr O'Neill's heating, so it remained on in the middle of a heatwave. An engineer was called to fix his door hinge, but not his heating. Mr O'Neill desperately needed a reduction in the temperature of his flat, first and foremost by the heating being fixed, but Care Outlook staff did not deal with this. He also needed immediate rehydration. When he was admitted to hospital, he was in deficit by about three litres. He was offered a drink by care staff at mealtimes, but he needed constant prompting and encouragement to drink enough. His deterioration was not recognised.
6	**ACTION SHOULD BE TAKEN** In my opinion, 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 5 April 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 following.

	• [redacted] niece of Joseph O'Neill • Hackney Borough Council • Care Quality Commission for England • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 05.02.21 *ME Hassell*