ANNEX A

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. [redacted], Registered Manager Sunnyside Nursing Home** **2. Managing Director, Sunnyside Nursing Home** **3. Care Quality Commission**
1	**CORONER** I am Sarah Watson, Assistant Coroner, for the Coroner area of West Yorkshire (Eastern)
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 17 August 2020 I commenced an investigation into the death of John Dickinson, aged 83. The investigation concluded at the end of the Inquest on 20th July 2021. The medical cause of death was: 1a) Urosepsis 1b) Klebsiella Oxytoca Infection II) Diabetes Mellitus Type 2, Hypertension The conclusion as to death was a narrative conclusion that John Dickinson died as a consequence of a naturally occurring disease in circumstances where earlier admission to hospital may have prolonged life.
4	**CIRCUMSTANCES OF THE DEATH** John Dickinson was admitted to hospital on 23 June 2020 following multiple falls in the preceding 24 hours. He was diagnosed with a gall bladder infection and received antibiotic treatment. His condition improved during the course of his admission and on 11 July 2020 he was moved to Sunnyside Care Home Leeds to occupy a community care bed. On 15th July 2020 a GP attended and advised "... ensure plenty of food and fluids, if reduce fluid intake call 999". He was commenced on a course of antibiotics which was completed on 21st July 2020. It is not clear from the records what quantity of food and drink Mr Dickinson was consuming from this date due to deficiencies in the documentation. From 28th July 2020 Mr Dickinson began refusing food other than breakfast however there was no record as to his general presentation. On 2nd August 2020 he was admitted to hospital in Leeds. The referral stated that he had had poor nutritional intake for the previous 48 hours. He was diagnosed with having

	acute kidney impairment, dehydration and markers suggesting an infection. He was diagnosed with having a urinary tract infection, separate to the gall bladder infection. Despite antibiotics and fluids his condition deteriorated and he was placed on palliative care whereupon he died on 9th August 2020.
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) The record keeping was inconsistent and lacked detail on general wellbeing. (2) The volume of forms to be completed meant that there was not a single document from which a holistic view of him could be obtained. (3) Assumptions were made regarding generally refusing food when if the food records had been checked it would have been noted that he consistently refused the fourth meal of the day until the 28th July 2020. (4) Advice from the GP on 15th July 2020 were handed over orally at a 'huddle' and no record was kept as to this being mentioned. (5) Following the GP's visit, no action plan regarding monitoring his fluid or food intake was created nor was any instruction placed in his room to prompt monitoring. (6) The inconsistent and sometimes non-existent record keeping meant that Mr Dickinson was not assessed as deteriorating until 48 hours before his admission to hospital rather than 5-6 days before when he began refusing lunch and evening meal.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 16th September 2021. 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 family of Mr Dickinson. I have also sent it to Helen Whatley MP, Minister of State for Care 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	**SIGNED :** Sarah Watson **DATED** : 22nd July 2021 **SARAH WATSON, ASSISTANT CORONER**