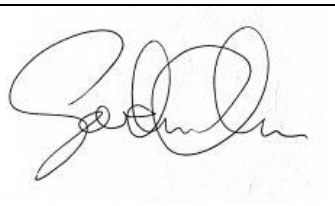
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. My Care Ltd;** **2. My The Orchards Ltd;** **3. All other interested persons, namely:-** **a. The family;** **b. Dr [redacted], GP** **c. Sherwood Forest Hospitals NHS Foundation Trust** **d. Nottinghamshire County Council** **e. The Care Quality Commission**
1	**CORONER** I am Mr Gordon Clow, Assistant Coroner for the coroner area of Nottinghamshire.
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 21 January 2020 an investigation was commenced into the death of Mr Murray Hyslop who was born on 21 March 1938 and who died, aged 82, on 16 January 2021. The investigation concluded at the end of the inquest on 30 September 2021. The conclusion of the inquest was a narrative conclusion: "*By 18 December 2020 Mr Hyslop's poor health was demonstrated within the pattern of his fluid consumption. He presented as significantly frail and unwell on 20 and 21 December 2020 as a consequence of illness exacerbated by dehydration and malnutrition. No medical assistance was sought for Mr Hyslop until 23 December 2020.* *Mr Hyslop was admitted to hospital on 24 December 2020 and received active treatment. Notwithstanding that treatment, Mr Hyslop did not recover and he died from natural disease on 16 January 2021. Had medical assistance been sought at an earlier stage, it would have been more likely that Mr Hyslop could have been successfully treated*."
4	**CIRCUMSTANCES OF THE DEATH** Mr Murray Hyslop was elderly and in need of residential care. He remained in relatively good health until December 2020. In mid-December 2020 he contracted Covid-19 and developed signs of ill health. Despite encouragement, from 16 December 2020 onwards Mr Hyslop drank very little and his appetite was markedly reduced. From 20 December 2020 onwards, Mr Hyslop drank even less and, on some days, almost nothing at all. As a consequence, he became dehydrated and malnourished, exacerbating his physical condition and resulting in acute kidney injury.
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 could 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) Prevention of pressure damage – there was a lack of appreciation of the need to consider Mr Hyslop's extreme vulnerability to pressure damage when he was very unwell, dehydrated, malnourished and largely immobile. Policies and practices supported only monthly review of his needs and that is insufficiently responsive in order to appropriately prevent damage from occurring; (2) Identifying a resident in need of medical attention – some of the difficulties in Mr Hyslop's care were exacerbated by the outbreak of Covid-19, but there was no evidence of any expectation upon any members of staff to consider a broader view of Mr Hyslop's presentation than how he was on a particular day. The witnesses did not seek to suggest that they usually did this but were unable to during the outbreak and so I consider that it is likely that this was an issue was existed both before and after the outbreak. I was more reassured in this area by "Restore 2" materials and training which provide very clear and helpful guidance to carers. It is not clear to me how this training, which has been completed by the registered manager, has been effectively cascaded to frontline care staff and their evidence to me suggested that this has not happened to date; and (3) Learning from adverse events – the culture within senior staff of obfuscation and denial when issues regarding care are raised was of significant concern to me as it is hard to have confidence that, as they said to me, "lessons will be learned". It was appropriate for the senior management to be supportive of their frontline staff who, as set out above, worked hard when the care home was understaffed. They were not, however, open minded to consider areas where significant changes in practice and culture needed to take place.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 13 December 2021. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting 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 Interested Persons set out above. 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	 **Mr Gordon Clow, HMAC** **14 October 2021**