Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], CEO, Four Seasons Healthcare** **2. [redacted] – Group Director of Care Quality**
1	**CORONER** I am HEIDI J CONNOR, Senior Coroner for Berkshire for the coroner area of Berkshire
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 12th May 2021 I commenced an investigation into the death of Colm MCCABE aged 79. The investigation concluded at the end of the inquest on 11 January 2022. The conclusion of the inquest was natural causes contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Mr McCabe was a 79 year old genetleman who had been diagnosed with diabetes in 1992, and dementia in 2012. He was admitted to the Royal Berkshire Hospital on 3rd March 2021 and discharged to a "discharge to assess" bed at Berkshire Care Home in Wokingham, Berkshire on 9th March last year. There was some confusion about insulin administration at the time of his discharge from hospital, but no attempt was made by the home to clarify this. His blood sugar levels were not monitored at the care home between the afternoon of 15th March and the morning of 22nd March 2021 despite a result of 16.5 mmol/L on the morning of 15th March. He was eating and drinking very little. The blood sugar monitoring plan was based on staff's experience of an entirely different patient, who was not insulin dependent. No medical review of Mr McCabe was sought before 22nd March, by which time he was borderline comatose, dehydrated and hyperglycaemic, with a blood sugar level of 27.7 mmol/L. He was transferred to the Royal Berkshire Hospital, Reading, Berkshire, on 22nd March, but died there on 24th March 2021. His cause of death was 1a Pneumonia 1b Hyperosmolar-hyperglycaemic state 1c Type II Diabetes Mellitus Part II Dementia The evidence was clear that there was a link between the failure to monitor blood sugar levels and administer insulin accordingly on the one hand, and his admission with hyperglycaemia and subsequent death on the other. In considering my responsibilities under Regulation 28, I was concerned about the level of candour and the depth of investigation by Four Seasons and Berkshire Care Home in

	relation to this matter.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. A number of the policies referred to at the inquest were in fact already in place at the time of this death. Many of these were not followed. I remain concerned about recruitment of staff, training of staff, and appraisals of staff. 2. Whilst I was advised that a new management team is working at this care home, I remain concerned about auditing of the effectiveness of this. We heard evidence that auditing was taking place at the time of this death, but this appears to have missed significant factors, including the fact that a 72 hour review was not carried out, that neither the 72 hour review nor any subsequent management of the patient picked up the blood sugar monitoring issue, nor did they seek clarification of this point with the hospital, the GP or community diabetic nurses. 3. I heard evidence about investigations carried out by the home, and the fact that initial responses to enquiries from the CQC suggested that the management had been appropriate. I am concerned to know to what extent care homes run by Four Seasons carry out full and candid investigations and produce reports accordingly, and what training is given to managers in this respect?
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 28 March 2022. 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 [redacted] **Daugher of the Deceased** **Wokingham Medical Centre – GP Practice** **RBH In-House Legal Team** **CQC** **Wokingham Borough Council** **Berkshire Care Home Legal Team** I have also sent it to [redacted] **(Former Manager of this Care Home)** who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 31/01/2022**  **HEIDI J CONNOR** **Senior Coroner for Berkshire for Berkshire**