REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Managing Director [redacted] Holmes Care Group Limited 228 St. Mary's Lane Upminster RM14 3DH
1	**CORONER** I am Area Coroner for Essex
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**
4	**CIRCUMSTANCES OF THE DEATH** Maria Howell who died on the 28th September 2019 at Basildon University Trust Hospital, Nethermayne, Basildon, was resident in Cranham Court Nursing Home and she had a RIG tube in place. The nurse on duty noticed that the RIG tube had fallen out, but was not trained to reinsert, she delayed calling for an ambulance so the timings as to when this fell out was unknown. She was taken to Basildon A & E and at the hospital some hours later she had the PEG button reinserted and was discharged home. The same nurse was on shift that evening and Mrs Howells became unwell, around 7pm. No ambulance was called by the nurse until the day nurse came on duty, some 12 hours later. Mrs Howell was taken by ambulance where it was diagnosed that she had Peritonitis and sadly passed away on the 28th September 2019
5	**CORONER'S CONCERNS** During the course of the inquest it 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. – That the Care Home had a resident with specific complex needs, and they had no qualified nursing staff to reinsert a RIG tube which is time critical. That they employ staff whose clinical judgement on someone who is critically ill does not necessitate urgent medical attention.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe 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, 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 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	**Date. 27th January 2022** **Name Michelle Brown HM Area Coroner Essex**