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], **Head of Quality at Exemplar Healthcare** 2. **Manager, Copperfields Nursing Home** 3. **Sajid Javid, Secretary of State for Health and Social Care**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East)
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 Coroner's (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 8 July 2021 I commenced an investigation into the death of Mark Anthony Athias, aged 55. The investigation concluded at the end of the Inquest on 27 January 2022. The conclusion of the inquest was a narrative conclusion that was attributable to 1(a) Sepsis 1(b) Pseudomonas aeruginosa bacteraemia after he was admitted to hospital from his nursing home due to a urinary tract infection associated with problems relating to his catheter.
4	**CIRCUMSTANCES OF THE DEATH** Mr Athias had multiple physical and mental health issues. He was subject to recurring urinary infections and had a long-term catheter inserted in hospital in May 2021. On 2 July 2021, difficulties were encountered with his catheter. As the nursing home did not have a sterile replacement catheter in stock, an ambulance was called, and he was admitted to hospital. Despite treatment, his condition deteriorated and he died at 6.10am on 6 July 2021.
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 nursing home did not have sterile replacement catheters in stock, despite being aware that Mr Athias had difficulties with his catheter, which had necessitated it being replaced twice in previous weeks. The mistakes made in ordering replacements had not been detected by the managers in the nursing home. 2. The catheter care plan had identified the need for his fluid intake and output to be monitored. The contemporaneous records kept were, however, inadequate. This hindered any assessment of his urinary problems. The managers in the nursing home had not noticed the inadequacy of such records.

	3. The handover record for 2 July 2021 was missing, having allegedly been overwritten. The managers in the nursing home did not appreciate this until an Adult Safeguarding Investigation was underway. 4. In order to ensure instructions were complied with, and without checks to ensure the contemporaneous records required to be kept were actually being maintained, there is a risk deficient record keeping could continue. 5. Managers of nursing homes should make checks sufficiently often to ensure the records required to be kept actually exist, and that they are preserved, so as to facilitate an analysis of trends in the medical condition of patients in the care of the nursing home
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 Friday 25 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], Solicitor for the estate of Mr Mark Anthony Athias I have also sent it to: [redacted], Safeguarding and Risk Manager, Leeds Safeguarding Adults Board Dr [redacted], St James's University Hospital, Leeds Teaching Hospitals NHS Trust [redacted], Care Quality Commission 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	28th January 2022 Kevin McLaughlin Senior Coroner