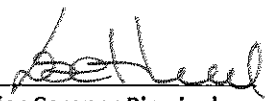
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Sandwell and West Birmingham Hospitals NHS Trust** 2. **Kerria Court residential home** 3. **DOLS team at Birmingham City Council**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S 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 06/04/2016 I commenced an investigation into the death of Winston Harris aged 76 who resided at Kerria Court residential home. The investigation concluded at the end of the inquest on 3rd August 2016. The conclusion of the inquest was that the deceased died from dilated cardiomyopathy contributed to by hypothermia and acute kidney injury which occurred after he absconded from City hospital on 17/03/2016. The medical cause of death was 1a. Pulmonary oedema 1b. Dilated cardiomyopathy 1c. Acute kidney injury and hypothermia in a patient suffering from dementia
4	**CIRCUMSTANCES OF THE DEATH** Mr Harris was a resident at Kerria Court as he suffered from dementia. He was admitted to the residential home on 05/02/2016. He absconded from the home that day due to his dementia. He was assessed as lacking capacity to make decisions for himself and an application for a deprivation of liberty safeguarding order (DOLS) was made to the local authority. On 12/03/2016 he complained of chest pain and was taken to City Hospital. His previous absconding and the fact that a DOLS application was being made was provided to the paramedics orally only. The care plan that accompanied the deceased to hospital did not mention the previous absconding or the DOLS application. The deceased was investigated at City Hospital and moved to several different wards. He was noted to be pleasantly confused. An echocardiogram confirmed severe right and left ventricular systolic impairment indicating dilated cardiomyopathy. He was transferred to ward D7 on 15/03/2016. On 16/03/2016 Mr Harris had attempted to leave the ward. As a result the door security was changed so that only staff could enter or leave the ward with security passes. On 17/03/2016 CCTV confirmed that Mr Harris left the ward behind a member of staff at 10.57 fully clothed, he then exited the hospital at 11.07 and was last seen walking down Aberdeen Road at 11.12. The police were informed. On 18/03/2016 the deceased was found sitting at a bus stop and paramedics were called at 08.21, arriving at 08.34. Mr Harris was taken to Queen Elizabeth Hospital In Birmingham where he was found to have an acute kidney injury and be severely hypothermic. He continued to deteriorate and passed away on 22/03/2016.
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. – **Kerria Court residential home** (1) The care plan for Mr Harris did not deal with his risk of absconding. As a result when he was transferred to City Hospital with his care plan there were no details of his previous absconding behaviour. (2)When Mr Harris was transferred to hospital, without an escort, there was no written documentation provided to confirm that a DOLS had been applied for and that he was an absconding risk. **Sandwell and West Birmingham Hospitals NHS Trust** (3) At no time did staff consider if Mr Harris should be subject to an emergency DOLS despite him having dementia and having tried to leave the ward on 16/03/2016. He had previously been assessed as requiring and DOLS. **Birmingham City Council** (4) The application for DOLS order was not processed before Mr Harris's death. I heard evidence that it often takes many months to process a DOLS application. Given these are extremely vulnerable people applications should be processed more quickly.
6	**ACTION SHOULD BE TAKEN** In my opinion 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 by Wednesday 28 September 2016. 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: Mr Harris's family Care Quality Commission NHS England 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	03/08/2016 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**