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. The Chief Executive (Mr David Behan), Care Quality Commission, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA** **2. The Registered Nursing Home Association (Chief Executive – Frank Ursell), John Hewitt House, Tunnel Lane, Off Lifford Lane, Kings Norton, Birmingham. B30 3JN** **3. The Health and Safety Executive, Head of Health and Social Care Services Unit [redacted] Public Services – Sector Phase 1, Government Buildings, Ty Glas, Llanishen, Cardiff, CF14 5SH**
1	**CORONER** I am Donald Coutts-Wood,assistant coroner, for the coroner area of Leicester City and South Leicestershire
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 25th May 2012 I commenced an investigation into the death of Walter Gordon Powley. The investigation concluded at the end of the inquest on 4th October 2013. The conclusion of the inquest was "The cause of death was Acute Renal Failure due to Rhabdomyolisis and Metabolic Acidosis due to burns to legs. This followed Mr Powley being admitted to the Care Home and he fell against pipes. The jury considered that contributing to his death were: A lack of covering pipework, inadequate ongoing risk assessments, failure to adhere to procedures on giving and recording of medication. .
4	**CIRCUMSTANCES OF THE DEATH** Mr Powley died after he fell against radiator pipes underneath a radiator in his room at Western Park View Care and Nursing Home, Hinckley Road, Leicester. He fell on the 8th May 2012 having been admitted for emergency respite care on the 4th May 2012. When he fell Mr Powley's legs were not covered. He sustained one deep burn to his right leg and numerous superficial burns to both legs. These burns were the causes of the complications that led to his death 8 days later in hospital.
5	**<u>CORONER'S CONCERNS</u>** 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.Neither the pipes that he fell against nor the valves that connected those pipes to the radiator, were covered. HSE published guidance indicated that the maximum temperature of such pipes should be 43 degrees centigrade. Readings taken from uncovered pipes both in Mr Powley's room and other rooms in the Home indicated that the temperatures ranged between 60 degrees centigrade and more than 70 degrees centigrade. Evidence was given at the Inquest that a number of other residential homes in this area did not have pipes and valves covered. It may well be therefore that this applies throughout the country. 2.It was therefore also apparent that there had not been a risk assessment of the physical circumstances in that room, and whether it was therefore safe for a particular resident. 3.Western Park View had been inspected by the Care Quality Commission and the Local Authority on a regular basis. Evidence indicated that these matters referred to had not been recognized by those bodies.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 29th November 2013. 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 1.Western Park View Care Home; 2.the family of Mr Powley 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	**4th October 2013** **Signed ……..**