Tony Brown LLM
H M Senior Coroner
North Northumberland

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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **NIGHTINGALES HOME HELP SERVICE** **42 The Square** **Kelso** **Roxburghshire** **TD5 7HL**
1	**CORONER** I am Tony Brown, senior coroner, for the coroner area of North Northumberland
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 17th October 2013 I commenced an investigation into the death of Jack Basil Lynn, age 86 years. The investigation concluded at the end of the inquest on 14th February 2014. The conclusion of the inquest was that Jack Basil Lynn died from natural causes, the medical cause of death being:- 1a Haemopericardium 1b Ruptured Acute Myocardial Infarction 1c Coronary Artery Thrombus
4	**CIRCUMSTANCES OF THE DEATH** Jack Basil Lynn lived alone at his home address. Staff from care providers Nightingales Home Help Service attended Mr Lynn on a daily basis morning and night, to ensure he was prompted to take his medication and to check on his well being. A carer who visited Mr Lynn on the 15th October 2013 for a planned 15 minute visit entered the house with a key. The carer observed that Mr Lynn was not downstairs when she called and assumed that he must have gone back to bed. She believed that Mr Lynn had taken his medication for that morning by looking at a plate on a table where he normally put that morning's tablet, but it was probable in the circumstances that he had not taken his medication on that day. No further checks on Mr Lynn were made by the carer at that time to ensure his well being before she closed the door and left the property. Later that

	evening the same carer returned to the property and as Mr Lynn was still not downstairs she went upstairs to check on him. Mr Lynn was found unresponsive on the bathroom floor. Paramedics were called but could not assist and Mr Lynn's death was pronounced at 20.03 hours.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence disclosed 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. – Arrangements put in place for daily prompting with medication did not include keeping a medication communication sheet at Mr Lynn's home address as a continuous record of his medications. This would have allowed for a more reliable check by visiting carers or family members as it would have clearly indicated whether medications were being taken regularly. The absence of any check on Mr Lynn's safety or well being during the allocated 15 minute visit on the morning of 15th October 2013 exposed Mr Lynn to potential risk, albeit that the sudden cardiac event which occurred could not have been prevented. The risk was present, nonetheless, and creates a risk that future deaths might occur if action is not taken.
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 by18th April 2014. 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] I have also sent it to the Care Inspectorate 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 18th February 2014** **TONY BROWN** **HM Senior Coroner for North Northumberland**