REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS. THIS REPORT IS BEING SENT TO: Operations Director, HC one of many, Southgate House, Archer Street, Darlington, County Durham, DL3 6AH CORONER I am John Pollard, senior coroner, for the coroner area of South Manchester **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 **INVESTIGATION and INQUEST** On19th March 2014 I commenced an investigation into the death of ALBERT FLYNN dob 29TH December 1929. The investigation concluded on the 2nd July 2014 and the conclusion was one of Natural Causes. The medical cause of death was 1a Subdural Haemorrhage 11 Vascular Dementia and Parkinson's Disease. CIRCUMSTANCES OF THE DEATH Mr Flynn was resident in Appleton Manor Residential Home. On the 14th March 2014 he was taken to Stepping Hill Hospital in Stockport with a suspected Deep Vein Thrombosis in the left leg. He was treated for this with Enoxaparin which is a blood thinning agent. The following night he appeared to the staff at his residential home, to be restless and unable to sleep and they were concerned lest he fell out of bed. They therefore dressed him and placed him in a chair in the dining room/lounge. Mr Flynn was then left in that chair from 2.00am to 12.00. mid-day. During this time he had no food, no fluids and none of his prescribed medication. Eventually the care staff called upon the qualified nurse working on the floor below to attend to Mr Flynn. She described the situation as his having been left far too long and she insisted that he be moved by hoist and placed in his room. A number of the carers admitted under oath that they could not rouse him but thought he was merely sleeping. As it turns out Mr Flynn was suffering with a severe cerebral bleed which proved to be fatal. **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. Whilst the care staff members were apparently concerned as to the condition of Mr Flynn, none of them was sufficiently well trained or qualified to make an informed decision as to how he should be treated. 2. As a result of the above, he was left sitting in a chair, partially dressed,

	 without food, fluid or medication for a period of approximately 10 hours. None of the staff gave any indication of any, or any proper, training in the assessment of this type of event, nor did they attribute any or any sufficient weight to the fact that he had been administered blood thinning drugs the previous day. The staff did not seem to appreciate the importance of administering prescribed medication.
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 27 th August 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 namely (daughter of the deceased).
	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	2 nd July 2014 John Pollard, HM Senior Coroner