### **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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#### THIS REPORT IS BEING SENT TO:

Healthcare Management Solutions Ltd Drakes Court 302 Alcester Road Wythall Birmingham B47 6JR

# 1 CORONER

I am David Clark Horsley, senior Coroner for the Coroner area of Portsmouth and South East Hampshire.

## 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 30<sup>th</sup> July 2015 I commenced an investigation into the death of James Robertson, age 84. The investigation concluded at the end of the inquest on 10<sup>th</sup> February 2016. The conclusion of the inquest was:

- Medical cause of death:
  - 1a) Severe Coronary Artery Disease, Aortic Stenosis
  - Cerebrovascular Disease, Chronic Obstructive Pulmonary Disease, Urinary Tract Infection
- Coroner's Conclusion at to death:

Death due to Natural Causes.

### 4 CIRCUMSTANCES OF THE DEATH

Mr Robertson died on 22<sup>nd</sup> July 2015 whilst resident at Cams Ridge Care Home, 7 Charlemont Drive, Fareham. He had last been checked in his room around 13.00 hours. When checked again around 15.30 hours, he appeared to be deceased. This was confirmed by attending paramedics at 15.50 hours.

## 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) At Mr Robertson's Inquest, his care notes were referred to and I was told that carers were not required to accurately report the time of carrying out checks on him. This meant the Inquest could not accurately ascertain when he had been checked by care staff on the day of his death.
- 2) I was also told that whether a resident at Cams Ridge was covered by DNACPR was indicated by a coloured sticker on the door of the resident's room and in centrally-located notes. The sticker on the door was not appreciated by a nurse who attended to him when he was found unresponsive and who then went to look in his notes, delaying resuscitation efforts. I was told that it would be better if DNACPR status was included on a resident's shift hand over notes which

would be more guickly accessible than the centrally-located notes. 3) I was also told that there are no national standards for what should be included in emergency resuscitation packs kept at nursing homes and in consequence, the pack brought to assist Mr Robertson was lacking useful equipment, particularly a suction unit. 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. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report. namely by 11<sup>th</sup> April 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. **COPIES and PUBLICATION** 8 I have sent a copy of my report to the Chief Coroner, to Mr Robertson's family, to the Care Quality Commission and to Hampshire County Council Adult Services. 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. Monday, 15th February 20 SIGNED BY CORONER 9 **David Clark Horsley**