	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Manager, Acorn Lodge Care Home** **15 Atherden Road London E5 0QP**
1	**CORONER** I am Jacqueline Devonish, assistant coroner, for the coroner area of Inner North London
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 9 December 2015 I commenced an investigation into the death of Doreen Mattinson, aged 80 years. The investigation concluded at the end of the inquest on Thursday 14 April 2016. The conclusion of the inquest was that the medical cause of death was Bronchopneumonia and Pulmonary Embolus due to Carcinoma of the Left Lung. The conclusion as to the cause of death was that the death was from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Doreen Mattinson became a resident of Acorn Care Home on 2 February 2015 when she had been assessed as not having the capacity to reside in sheltered accommodation. On 7 July 2015 Hackney Social Services issued a Deprivation of Liberty Order due to her inability to make decisions about her accommodation, care or treatment as a result of her diagnosis of dementia. Other comorbidities included Chronic Obstructive Pulmonary Disease (COPD), Cerebrovascular Accident (CVA) and recurrent falls. Her health remained stable until 27 October 2015 when she developed a cough. The GP attended Doreen Mattinson at the request of Acorn Care Home on six occasions between 28 October and 11 November 2015 due to concerns about the cough, and a possible CVA. She was initially treated with a nebuliser, given her COPD. When the cough had not improved by 11 November she was treated with antibiotics for a suspected chest infection. On 12 November 2015 Doreen Mattinson deteriorated rapidly and with laboured breathing. The Clinical Manager, who is a registered nurse, attended Mrs Mattinson together with two Senior Health Care Assistants. The Clinical Manager administered oxygen at a 1 litre flow utilising a lifeline cylinder and mask.
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) The London Ambulance Service attended Mrs Mattinson on 12 November 2015 and made a Safeguarding Report relating to the use of the oxygen. It had been reported that Mrs Mattinson had been lying supine on the bed saturating at 84% and struggling to breath. The oxygen could not be heard to be running and it was noted that only 1 litre was running when this should have been a15 litre flow with the mask applied.

	(2)There was no recognition by the Clinical Manager or those present on 12 November 2015 of the level of oxygen to be used in an emergency situation or as to the importance of sitting the patient in an upright position. (3)There was no evidence of training of the Clinical Manager, who was a registered nurse and the only member of staff on the residential unit on that day who would be expected to administer oxygen.
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 13 June 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: [redacted] I have also sent it to Hackney Social Services and the CQC 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	**18 April 2016** Jacqueline Devonish