REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sheffield City Council, Communities – Assessment & Care Management Services**
1	**CORONER** Christopher Peter Dorries, senior coroner for the coroner area of South Yorkshire (West)
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 the 17th September 2015 I commenced an investigation into the death of Mrs Marjorie Nesbitt (aged 97). The investigation concluded at the end of the inquest on 14th June 2016. The conclusion of the inquest was that Marjorie Nesbitt had died of hyperthermia in the presence of ischaemic heart disease and pulmonary emphysema with old age and frailty as contributing factors. I returned a conclusion of misadventure noting that Mrs Nesbitt had requested her carers to increase the power of a convector heater but that this then remained on overnight causing a very hot room. Mrs Nesbitt's condition was such that she could not regulate her own body temperature.
4	**CIRCUMSTANCES OF THE DEATH** Marjorie Nesbitt lived on her own with carers attending four times a day. There is no complaint about the conduct of the carers at any time. On Friday, 11th September 2015 carers noted sparks within the vicinity of a wall socket where two items were plugged in. One was the power move to Mrs Nesbitt's bed, the other was an oil filled free-standing radiator which was generally the major regulator of temperature in the room. The company providing the carers caused an electrician to attend almost immediately and it was noted that the socket was defective and that the plug to the oil filled radiator was partly melted. No doubt all of this would have been fixed in due course but the immediate action of the electrician was to say that the socket and in particular the oil filled radiator with its defective plug could not be used again until mended and checked. The carers, and indeed Mrs Nesbitt were keen to follow this advice. The only remaining heating device for the room was a fan heater which was away from the immediate area of the bed and was left during the day on its lowest setting, providing a comfortable

	atmosphere. However, at the time of the evening visit there was discussion between the carers and Mrs Nesbitt leading to the fan heater being turned up, most likely to its second setting out of three. Unfortunately Mrs Nesbitt was bedbound, the fan heater was out of reach and there was not going to be a further visitor until the carers morning round. When the morning carers attended they found that the fan heater was still in the same position and that the room was extremely hot. Mrs Nesbitt was in the last stages of life, still in her bed. All proper measures were taken by the carers in calling for the Emergency Services etc., but Mrs Nesbitt could not be saved. The inquest found that the medical cause of death was hyperthermia in the presence of ischaemic heart disease and pulmonary emphysema. In simple terms the overheating of the room, with Mrs Nesbitt's inability to regulate her own body temperature through age and illness had taken her life. It was noted that her old age and frailty were contributing factors.
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) It is accepted that the circumstances were unusual and none of the carers were likely to have been trained what to do in such a situation. Indeed, it is accepted that they were placed in a difficult position, not turning the heater up would lead to the client being cold during the night, turning it up with no one due in to review the situation led to an uncomfortable and ultimately fatal situation for Mrs Nesbitt. (2) Nonetheless, it is difficult to say that this would be a completely unique situation and it is not impossible that other carers will be faced with similar situations in the future. What is a carer supposed to do in that situation? One supposes that the only potential remedy might be to include the circumstances of this case as a discussion in training of carers.
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. In fairness, beyond inclusion of the case as a training tool I cannot personally see an easy remedy.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **11th October 2016**. I may extend the period if requested. 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. I have also sent a copy to [redacted] (the deceased's son) and [redacted] (the deceased's nephew). 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	**25th July 2016** **C P Dorries**