REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Abbey Court Independent Hospital**
1	**CORONER** I am Nicholas Rheinberg senior coroner, for the coroner area of Cheshire
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 10th October 2014 an investigation into the death of Brian Gerrard aged 77 was opened. The investigation concluded at the end of the inquest on 28th November 2016. The conclusion of the inquest was that the deceased had died from natural causes, namely lack of eating due to dementia.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was suffering from moderately severe mixed Alzheimer's / vascular dementia, together with depression and intermittent infections. As a result he lost his appetite to the extent that despite encouragement to eat he became undernourished, his lack of eating being the immediate cause of his death.
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** relate to (1) the understanding of staff in relation to the proper management of a best interests meeting, (2) the identification of lack of capacity and (3) the implementation of Deprivation of Liberty Safeguarding procedures. All such deficiencies appeared to warrant an amendment of procedures and a requirement for appropriate training. On 26th September 2014 a best interests, multidisciplinary meeting was called at your hospital to decide upon what action to take to address the fact that the deceased was not eating sufficiently and might be close to death. Those present at the meeting included the deceased's named nurse who took the minutes of the meeting, the deceased's wife, a psychiatrist who was the deceased's responsible clinician and a General Practitioner from the deceased's medical practice. The meeting decided that it was in the deceased's best interests to remain at your hospital rather than being transferred to a general hospital for treatment. In that regard the minute of the meeting correctly reflected what had been agreed. However, it was also minuted that the deceased had determined to die and that to achieve this aim he was deliberately not eating and that he had capacity to make such a decision. Such did not represent the opinion of the psychiatrist / responsible clinician nor the opinion of the general practitioner, both of whom were of the view that the deceased did not have capacity and

	that he had not formulated a plan to die but that his lack of eating was a product of his illness. Thereafter an application for a Deprivation of Liberty Safeguard contained inaccurate and contradictory information and appeared to demonstrate a lack of familiarity with procedures. For instance, the application asserted that the deceased had capacity to make decisions with regard to his care needs when such did not represent the opinions of the clinicians responsible for the deceased's care.
6	**ACTION SHOULD BE TAKEN** In relation to the above three numbered concerns, in my opinion action should be taken to prevent future deaths and I believe you and 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 by 31st January 2017. 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 [redacted], the deceased's daughter and the Care Quality Commission. 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	**5th December 2016** **Nicholas, Rheinberg** **Senior Coroner**