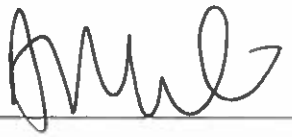
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive Stockport NHS Foundation Trust**
1	**CORONER** I am Alison Mutch, coroner, for the coroner area of South Manchester
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 26th October 2016 I commenced an investigation into the death of John Davies. The investigation concluded on the 6th April 2017 and the conclusion was a narrative one of **died of natural causes exacerbated by an infected pressure sore.** The medical cause of death was 1a Lewy Body Dementia;1b Parkinson's Disease; and 2 Infected Sacral Pressure Sore
4	**CIRCUMSTANCES OF THE DEATH** **John Anthony Davies had Lewy body dementia and Parkinson's disease. He was a resident at Cawood House Lapwing Lane, Stockport. His care needs were complex. He was identified as requiring a move from a residential care setting to a nursing home setting. Care was provided by the District Nursing Team and the GP. On the 7th September 2016 he was found to have an infected pressure sore. He was admitted to hospital. His prognosis was poor. On the 6th October 2016 he was moved to the Meadows for palliative care. He deteriorated and died on the 23rd October 2016 at the Meadows.**
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. There was no process in place for risk assessment plans to be completed when a resident's needs changed from care to nursing needs and a bed was awaited. 2. The District Nursing Team were unaware of the change in status and there was no system in place to involve them in discussions. 3. Patient records completed by the District Nursing Team lacked detail and were not completed in the required timescales. 4. There was no continuity of care provided by the District Nursing Team. 5. There was little evidence of communication and information sharing between the care home and the District Nursing Team 6. The Care Home notes were lacking in detail 7. A suitable nursing home placement could not be identified once it had been agreed that the Care Home was no longer the best place to meet the needs of Mr Davies 8. Advice was not sought by the District Nurses when they had difficulties examining Mr Davies

	9. The correct procedure was not followed on previous occasions when a trigger point was reached in relation to pressure relieving strategies.
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 21st June 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] son of the deceased, 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	**Alison Mutch** **HM Senior Coroner**  **26th April 2017**