




REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. The Chief Executive, Agrade Community Care Services, Unit 128, Coney Green Business Centre, Wingfield View, Chesterfield S45 9JW</p>
1	<p>CORONER</p> <p>I am M Jennifer Leeming, HM Senior Coroner for the Coroner Area of Manchester West.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 3rd of February 2017 I commenced an investigation into the death of John Ramsden, 82 years, born 23rd August 1934. The investigation concluded at the end of the Inquest on 5th July 2017.</p> <p>The medical cause of death was:-</p> <p>Ia Bronchopneumonia II Dementia (terminal)</p> <p>The conclusion of the Inquest was John Ramsden died of Natural Causes.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>John Ramsden who suffered from dementia was subject to a Deprivation of Liberty Safeguarding Authorisation at Lever Edge Care Home where he resided. On the 8th January 2017 he was seen by a Doctor and medication for a suspected Urinary Tract Infection was prescribed. The pharmacy did not deliver that medication until 9th January 2017 and it was not therefore administered until that date. Whilst John Ramsden was a patient at Lever Edge Care Home his eldest daughter was consulted about his care but his other two daughters were not so consulted.</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows:</p>

	<p>1. During the Inquest evidence was heard that:-</p> <p>i. The evidence at the Inquest was that John Ramsden's eldest daughter was consulted about decisions to his care. However, John Ramsden's other two daughters were not consulted, particularly about his end of life care and about whether he should be admitted to hospital for treatment or not.</p>		
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion urgent action should be taken to prevent future deaths and I believe that you have the power to take such action.</p>		
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st August 2017. I, the Coroner, may extend the period.</p> <p>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.</p>		
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-</p> <ol style="list-style-type: none"> 1. [REDACTED] (daughter), [REDACTED] 2. [REDACTED] (daughter), [REDACTED] 3. [REDACTED] (daughter) [REDACTED] <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form.</p> <p>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.</p>		
9	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>Dated</p> <p>6th July 2017</p> </td> <td style="width: 50%; vertical-align: top;"> <p>Signed</p> <p></p> <p>M Jennifer Leeming, Senior Coroner</p> </td> </tr> </table>	<p>Dated</p> <p>6th July 2017</p>	<p>Signed</p> <p></p> <p>M Jennifer Leeming, Senior Coroner</p>
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