	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **VIRGIN CARE SERVICES LIMITED** **Lynton House** **7-12 Tavistock Square** **London WC1H 9LT**
1	**CORONER** I am Mr Andrew Haigh Senior Coroner for the coroner area of Staffordshire South
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 29 December 2017 I commenced an investigation into the death of Derek Reginald Smith aged 86 years. The investigation concluded at the end of the inquest on 15 June 2018. The conclusion of the inquest was 'An elderly gentleman with major natural health problems who had developed severe pressure sores'.
4	**CIRCUMSTANCES OF THE DEATH** Mr Smith lived at home but he could not manage any of his care needs and he was bedbound. He had regular attendances by carers. He had frequent visits by district nurses and other professionals saw him at times. He died at his home on 21 December 2017 from aspiration pneumonia. On 6th December he had been found to have a pressure sore on his sacrum that went down to the bone.
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. – It became apparent at the inquest that there was very little communication between the District Nursing team who attended Mr Smith and family members (and possibly little communication with the attending carers as well). There was also an issue regarding the availability of nursing records as well. It may be that Mr Smith's death could not be prevented but there could have been opportunities for helpful interventions by the family and earlier decision making regarding Mr Smith's treatment. Suitable communication could well be a significant factor in other cases. I wonder if systems could be changed to ensure better communication between the

	District Nursing team, family members and other agencies involved.
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 **14 August 2018**. 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: Mr Smith's family Midlands Partnership NHS Foundation Trust 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	**19 June 2018** ..... Andrew A Haigh HM Senior Coroner for Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 sscor@staffordshire.gov.uk