REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **This report is being sent to: Roseberry Care Centres, Haythorne Place, 77 Shiregreen Lane, Sheffield,S5 6AB**
1	**CORONER** Abigail Combes, Assistant Coroner for 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** In June 2018 I commenced an investigation into the death of Patrick Kelly. The investigation concluded following an inquest on 31 January 2019 where the conclusion was: • Natural Causes
4	**CIRCUMSTANCES OF THE DEATH** Patrick Kelly died as a result of sepsis part of which was as a result of a dental abscess. He was not compliant with dental hygiene and whilst it was this lack of compliance which contributed to the dental abscess; those providing care to him did not do everything in their power to ensure opportunities to improve his dental care were provided. He missed dental appointments and these were not rearranged with the care provider evidently placing little priority on the provision of dental care to their resident.
5	**CORONER'S CONCERN** During the course of the investigation my inquiries revealed matters giving rise to a 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 – a) Roseberry Care Centres do not place adequate weight on the importance of dental hygiene and the provision of dental services to their residents. This has potentially resulted in the worsening of a dental abscess in one case. b) Roseberry Care Centres do not have adequate policies in place to deal with missed dental appointments and the identification of when dental appointments may be required.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the named 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 14 June 2019. I may extend this period upon request. 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 [redacted]. Copies have also been sent to Sheffield City Council 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.

Abigail Combes

17th April 2019