ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mr M Hackett** **Chief Executive** **University Hospital of North Staffordshire** **Chief Executive's Office** **Trust Headquarters** **City General Site** **Newcastle Road** **Stoke-on-Trent** **ST4 6QG**
1	**CORONER** I am Ian Stewart Smith, senior coroner, for the coroner area of Stoke-on-Trent & North Stafforshire.
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 28th January 2015 I commenced an investigation into the death of Stephen Richardson aged 61 years. The investigation concluded at the end of the inquest on 11th August 2015. The conclusion of the inquest was that Mr Richardson died as a result of an accident with the cause of death being given as:- 1a Bronchopneumonia. 1b Fractured pelvis. II Downs syndrome
4	**CIRCUMSTANCES OF THE DEATH** The deceased was born with born Downs Syndrome and he had experienced learning difficulties all his life. After his mother's death he became a resident in care homes. He walked with a gait as a result of a previous right hip replacement operation, otherwise his mobility was good. He had not been prone to falls prior to November 2014. On 19 November 2014 the deceased complained to the care team of a painful right leg, indicating he had banged it. Later that day he was taken to Accident & Emergency department at the Royal Stoke University Hospital, Stoke-on-Trent. An x-ray revealed soft tissue injury but there was no fracture evident. On 17 December 2014 the deceased had been found on the floor in the hallway at the care home. He was thought to have suffered another fall but could not explain what had happened. Advice was sought from the National Health Service Help Line and he was given analgaesia. On 21 December 2014 the staff at the home became concerned about a possible hip injury. The deceased was taken again to the University Hospital where he was diagnosed with abdominal distension probably due to constipation and he was discharged. On 24 December he was discovered with fresh bruising to his left hip and thigh. He was taken once again to the University Hospital where a fractured pelvis was diagnosed. He was

admitted. The fracture was treated conservatively. He developed a chest infection. He was discharged on 7 January 2015 but he was not well. On 8 January he was readmitted to the University Hospital with a temperature. His condition deteriorated and he died in hospital on 16 January 2015 at 1.20am.

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. –

At the inquest I heard evidence from two professional carers for the deceased. They drew to my attention concerns which arose from nursing on ward 225 at the Royal Stoke University Hospital. Care was needed with what the deceased took orally. His food needed to be softened and drinks had to be given via a normal cup or glass. He had Downs Syndrome and he did not know better himself. He was, despite notices above his bed, fed chocolate biscuits, pastry, baked beans and other solid foods all of which he might have aspirated. Drinks were often given with Tippee cups or in glasses with straws, both of which were inappropriate and again could have caused aspiration. Four copies of 'traffic light notes' were handed in to avoid this type of problem and the carers when visiting consistently had to reinforce these messages to nursing staff. It is unlikely that he did aspirate but he might have done. It is depressing to note the frequent lack of care and attention to detail and I would like a report from the Ward Manager as to the issues raised.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and/or 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 16th October 2015. 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 following Interested Persons:-

1. Chief Coroner, Regulation 28 Reports, Chief Coroner's Office, 11th Floor Thomas More Building, Royal Courts of Justice, The Strand, London, WC2A 2LL
2. [redacted] Healthcare Governance Manager Patient Safety, UHNS Trust Headquarters, City General Hospital, Newcastle Road, Stoke-on-Trent, ST4 6QG
3. [redacted] sister of the deceased).
4. [redacted] (Care home manager).

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 [signature] 18/8/2016