REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester 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 5th March 2018 I commenced an investigation into the death of Averil Skoric. The investigation concluded on the 2nd October 2019 and the conclusion was one of **Narrative: Died from complications of positional asphyxia contributed to by positioning and her underlying frailty**. The medical cause of death was: **1a) Bronchopneumonia with Positional Asphyxia on a background of Frailty and Vascular Dementia; II) Chronic Obstructive Pulmonary Disease**
4	CIRCUMSTANCES OF THE DEATH Averil Skoric had vascular dementia and had become increasingly frail in the months prior to her death. As a result her mobility was very limited. On 3rd March 2018 she was put to bed on her back in the care home where she was residing. On 4th March 2018 she was found on her front. On the balance of probabilities she had rolled onto her front having been left on her side in a way that made it easy for her to move into an unsafe sleeping position. She had died from positional asphyxia as a result.
5	<u>CORONER'S CONCERNS</u> 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. –

	The inquest was told that: Mrs Skoric was a vulnerable resident who lacked capacity. Once she was on her front she was unable to move herself back into a safe sleeping position. She had to be regularly moved during the course of a night to check to see if she needed changing. There was no clear guidance available to care home staff locally or nationally about safe sleeping positioning of vulnerable adults in their care to avoid this cadre of adults being placed in a position which created an increased risk of unsafe sleeping.
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 10th January 2020. 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 1) [redacted] on behalf of the family 2) Clyde & Co Solicitors on behalf of Riverside Care Home 3) Care Quality Commission, 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 OBE** **HM Senior Coroner** **15.11.2019**