REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Manor Court Healthcare Ltd on behalf of Anson Court Residential Home** **2. Medical Director, Walsall Manor Hospital, Walsall Healthcare NHS Trust**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 25 March 2021, I commenced an investigation into the death of Mrs Tripta Bhanote. The investigation concluded at the end of the inquest on 4 August 2021. The conclusion of the inquest was a short form conclusion of open conclusion: The cause of death was: 1a Unascertained
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Bhanote was 86 years old. She had a background medical history of dementia and diabetes. Mrs Bhanote had moved into Anson Court residential care home on 26th March 2020 for respite care due to family circumstances at the family home at that time. ii) The placement was secured by the Walsall Local authority social services department. iii) She initially had trouble settling into the new environment and needed further 1:1 care and change in medication (Risperidone). iv) The respite period was subsequently extended into May 2020. v) She was found on the floor of her bedroom on the 5 May and had sustained bruising to her face and shoulder. vi) On the 9 May she was again found on the floor at around 4.45am and no apparent injuries were found. She was placed back into bed by care staff. Later that morning at around 9am she was again found on the floor by care staff. vii) Her condition declined rapidly, and there was confusion amongst staff

	whether a "Do not attempt to resuscitate (DNAR)" order was in place. viii) She sadly passed away a short time later.
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. – 1. Evidence emerged during the inquest that there was a lack of clarity and understanding by care staff in the requirements for escalation to emergency services when a patient/resident becomes acutely unwell. 2. There was lack of clarity and understanding by care staff of the role of the enhanced care and quality team and circumstances for referral to them. 3. There was evidence of poor procedures in place in identifying the DNAR status of residents.
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. 1. The care home owners may wish to consider reviewing their training and guidance on DNAR and escalation to emergency services. 2. The Hospital Trust may wish to consider reviewing their guidance and communication with care homes in relation to the role of the Enhanced care and quality team.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 November 2021. 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; Family. 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	**16 September 2021**

	Mr Zafar Siddique **Senior Coroner** **Black Country Area**