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. [redacted] **Corbett House Nursing Home, Droitwich Spa, Worcestershire;** 2. [redacted] 3. **Care Quality Commission;** 4. **Worcestershire County Council.**
1	**CORONER** I am James Puzey, assistant coroner, for the coroner area of Worcestershire
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 14 December 2021 HMSC David Reid commenced an investigation into the death of Peter Anthony Joseph Pearson, aged 78. The investigation concluded at the end of the inquest on 19th August 2022 which I heard. The conclusion of the inquest was that the medical cause of death was aspiration pneumonia and that Mr Pearson died from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr Pearson died at the Worcester Royal Hospital on 6 December 2021 from aspiration pneumonia. Prior to his admission he had been a resident at the Corbett House Nursing Home, Droitwich Spa ("the Home") from 26 November 2021. He was admitted to hospital on 5 December 2021 in a critical condition with erratic respiratory function and multi-organ disfunction. He was known to suffer from moderate dysphagia amongst other conditions. The aspiration pneumonia was in all probability acquired whilst he was resident at the Corbett House Nursing Home.
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) Mr Pearson's condition on 5 December 2021 was such that his daughter asked the agency nurse on duty for an ambulance to be called at 12.30 pm. None was called until 6.10 pm. The nurse did not complete the nursing notes

	for that day from 5am onwards so there is no written record of Mr Pearson's medical condition that day. Mr Pearson was found by paramedics alone in his room in a critical state. The staff on duty knew very little about him or his condition. The record of medications dispensed to Mr Pearson that day has been lost or is missing. He was found with medication in his mouth by paramedics. No records were kept of the checks of his oral cavity that were required to be undertaken twice a day. The Agency nurse has not been traced by the Home. The Inquest found as a fact that the failure to call an ambulance earlier amounted to a missed opportunity. (2) The former Registered Manager of the home at the time of the death is said by the Home's owner, to be responsible for shortcomings in the management of the home including "*providing false audit scores to senior management and cherry picking files which were presented for inspection.*" It is accepted by senior management that there were "*shortcomings*" in oversight of this manager. The deputy manager ("DM") at the time of Mr Pearson's death has now been promoted to Registered Manager despite the fact that her job description as DM include responsibility for supervising and managing staff and ensuring that all medications were recorded. (3) It is accepted on behalf of the Home that there was an "*ineffective investigation*" into Mr Pearson's death by the Home. Responsibility for that cannot not solely be attributed to the former Registered Manager. (4) Whilst there have been changes to audit practice, including the use of an external auditor it is not apparent that the oversight by senior management of the Registered Manager or DM has changed materially. Nor is it apparent what the current Registered Manager has done to date to improve record keeping and record retention and the supervision of nursing staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 9 November 2022. 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: [redacted] I have also sent it to the Care Quality Commission and Worcestershire County Council 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	**13 September 2022** **HMAC James Puzey**