REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Care Quality Commission**
1	**CORONER** I am Jenny Goldring assistant coroner, for the coroner area of Berkshire
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 19th November 2021, an Inquest was opened into the death of Frederick Robert Peter King aged 78 years old. A pre-Inquest review was held on 21st April 2022. The Inquest commenced and evidence was heard on 14th and 15th September 2022. The Inquest was adjourned part heard due to the unavailability of a witness due to ill health and the need to obtain replacement evidence. The evidence continued on 10th November 2022 and the Record of Inquest was completed. The conclusion was a narrative conclusion with a rider of neglect.
4	**CIRCUMSTANCES OF THE DEATH** Fred was a resident at the Birchwood Care Home in Newbury, Berkshire which was operated by the West Berkshire District Council. He had vascular dementia. He was admitted to the Royal Berkshire Hospital on 8th September 2021 and died on 9th September 2021 of an Acute Kidney Injury caused by dehydration. He did not receive adequate fluids in the 2 days prior to his death namely 985ml on 7th September 2021 and 770ml on 8th September 2021, when the recommended level for him was 1400ml, and the minimum level was 1200ml. I made a finding of neglect in the particular circumstances of this case, namely his high level of dependency (he could not feed or take fluid himself), the hot weather with outside temperatures of 26-30 degrees, the family concerns about his health not being recorded as conveyed to staff in the days prior to his admission. He was admitted to hospital on 8th September 2021 and given 3 litres of fluid, but he deteriorated and died on 9th September 2021. His death was contributed to by frailty and vascular dementia.

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) Fred did not receive adequate fluid in the 2 days prior to his death (985 and 770 ml). There were also 10 days during August and September 2021 when Fred received less
	than the minimum level of fluid, he required namely 1200ml. This was in the context of very high temperatures in the week of his death. (2) Inadequate record keeping in the Birchwood Care made it difficult to obtain the relevant records for the Inquest and the records obtained were incomplete for example in terms of what recording timings of fluid provision, whether pads were wet/dry and also family concerns regarding health were not recorded and conveyed. (3) There was no manager on the ground of the care home in the 3 days prior to Fred's death.
6	**ACTION SHOULD BE TAKEN** I was informed during evidence and in submissions at the conclusion of the Inquest as follows: • It was accepted that the record keeping had been inadequate. The data-keeping had been overhauled and there is now an electronic record system in place and no more paper records. • There is now an electronic system in place for recording fluid intake called Nourish. This ensures that there are fluid targets. By virtue of a drop-down menu it requires timings for fluid given and whether pads are wet or dry. • Complaints from families are recorded. • Records are now audited by 4 different managers and fluid records are checked daily. • There is also a full-time manager on the ground at the care home. I am satisfied that steps have been taken to improve the record keeping and the monitoring of fluid. However these systems are only as good as the data inputted and the audits conducted, and this will need to be kept under review. I am therefore drawing the above matters to the attention of the Care Quality Commission, aware that there have been recent inspections and a report issued on 25th August 2022 and aware that there will be future inspections. In my opinion action should be taken to prevent future deaths and I believe the Care Quality Commission has 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 2023. 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, the family of Frederick King and [redacted], the Care Quality Commission and to the West Berkshire District Council and Birchwood Care Home. 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	**15th November 2022**  **Jenny Goldring** **Assistant Coroner for Berkshire**