Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Amberley Hall Care Home** **55 Baldock Drive** **King's Lynn** **PE30 3DQ** **Athena Care Homes (UK) Limited** **Unit 5** **Russel House** **Southfields Business Park** **Hornsby Way** **Laindon** **Essex** **SS15 6TF**
1	**CORONER** I am Jacqueline LAKE, Senior Coroner for the coroner area of NORFOLK
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** On 02 May 2023 I commenced an investigation into the death of Geoffrey Alan WHATLING aged 82. The investigation has not yet concluded and the inquest has not been heard. **The medical cause of death was:** 1a) Infective Exacerbation of Chronic Obstructive Pulmonary Disease 1b) 1c) 2) Frailty, Old Age
4	**CIRCUMSTANCES OF THE DEATH** Mr Whatling entered Amberley Hall Care Home on 14 March 2023 for rehabilitation. On 8 April 2023, concerns were raised by Mr Whatling's family that he was unwell. At 17.37 Mr Whatling scored 7 on the NEWS2 requiring 999 call to be made. 111 was called. Further observations were carried out on 9 April 2023 (NEWS2 score 6), and 07.00 (NEWS2 score 5) and again on 10 April 2023 at 12.13 (NEWS2 score 9/10), when emergency services were called and Mr Whatling was admitted to Queen Elizabeth Hospital. Despite treatment Mr Whatling's condition continued to deteriorate and he died on 26 April 2023. The medical cause of death is 1a) Infective exacerbation of chronic obstructive pulmonary disease 2. Frailty, old age.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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 Whatling was not eating and drinking very much. A food and fluid chart was not fully completed. 2. Emergency services were not called on 8 April 2023 when Mr Whatling scored NEWS2 7 as required. 3. The evidence so far revealed is that 111 call taker was not made aware Mr Whatling had scored NEWS2 7. 4. Mr Whatling's observations were not taken hourly as required. 5. Some of Mr Whatling's observations were recorded on a piece of paper and were not logged in his Care Records 6. The Manager only became aware of gaps in the records following concerns raised by the family. 7. There is no evidence that any action has been taken following Mr Whatling's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 December 22, 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: [redacted] - NOK I have also sent it to: Department of Health Care Quality Commission (CQC) HSIB Healthwatch Norfolk NHS England & NHS Improvement 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	**Dated: 27/10/2023** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH