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. The Registered Manager, Whitkirk House, Colton Lodges Nursing Home, 2 Northwood Gardens, Colton, Leeds** **2. HC-One healthcare company** **3. Care Quality Commission**
1	**CORONER** I am John Hobson, Assistant Coroner, for the Coroner area of West Yorkshire (Eastern) District.
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 31st January 2024 I resumed an inquest into the death of Blanche Audrey Knowles, aged 91 years, which had been opened on 13th of September 2023. The investigation which has commenced on 7th September 2023 concluded at the end of the Inquest on 31st January 2024. A narrative conclusion was recorded after the conclusion of the evidence. The medical cause of death was as follows: 1a) Frailty of old age 2 Burns, multiple sclerosis, Ischaemic heart disease, hypertension, previous stroke The Narrative conclusion was recorded as follows: 'Blanche Audrey Knowles died of frailty of old age contributed to by the effects of long-standing medical conditions and the effects of burns suffered as a result of a hot drink being accidently spilled into her lap the temperature of which had not been adequately checked'.
4	**CIRCUMSTANCES OF THE DEATH** Blanche Audrey Knowles had a number of health conditions and was admitted for general nursing care within Whitkirk House, Colton Lodges Nursing Home, 2 Northwood Gardens, Colton, Leeds on 7th November 2022. On 15th July 2023 she was served a drink in a beaker cup the temperature of which had not been adequately checked by a staff member.

	The evidence heard at the inquest was that a 'warm drink' would be comprised of 'aired water' topped by cold water and that a member of staff would check the temperature of the cup/beaker by way of applying their wrist to the same. Blanche was not assisted with the beaker and it spilled causing her to suffer burns which upon assessment by a General Practitioner led to admission to hospital in the early hours of 16th July 2023. It was wholly apparent from the injuries that Blanche suffered that the temperature of the drink had not been checked in an adequate manner. The paramedics who attended Blanche on 16th July 2023 recorded that: *'The injury occurred on 15/7/2023 17.30. Mechanism of injury: Burn: thermal. Pt was given hot water to drink which pt spilt between her legs. Pt had cold compress/towels applied but no active cooling by running water for 20 mins. Pt was given Paracetamol at the time. GP OOH visit arranged – Ambulance called ppst GP assessment…'* Blanche was admitted to hospital in the early hours of 16/7/2023 and discharged on the same day. Thereafter she was treated and monitored accordingly. On 14th August 2023 paramedics were called as she was presenting with unresponsive episodes, weakness to her right side and difficulty with speech. Upon General Practitioner attendance she was prescribed antibiotics for a chest infection. Thereafter Blanche remained frail and on 29th August 2023 palliative care and anticipatory medication was discussed. On 1st September 2023 her condition deteriorated and she passed away her death being confirmed at 0930 hours.
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 **MATTER OF CONCERN** is as follows. – Whilst it was clear from the written and oral evidence provided to the inquest that measures had been implemented to address the risks from hot drinks, for example by the purchase and use of thermometers, upon questioning, the matter of the importance of assisting an individual who has suffered burns by way of 'cooling by running water' as noted by the Ambulance staff did not appear to have been adequately conveyed to staff, be that through training or by way of clear communication as operational matters/requirements in the nursing care context. The burns suffered by Blanche contributed to the cause of her death and whilst it was not established that the recorded failure to apply 'cooling by running water' to her injuries would have made a material difference, I remain concerned that the clear importance of applying 'cooling by running water' does not appear to be proactively flagged in relevant policies/procedures or by active practical/operational communications to staff.
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 9th April 2024 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, to Blanche Knowles' family and the HC-One healthcare company. I have also sent it to the 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	13th February 2024

John Hobson
Assistant Coroner