REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Executive Officer of Peabody,** **Peabody, 45 Westminster Bridge Road** **London, SE1 7JB** **2. CQC** **The Inspecting Officer for Location [redacted]** **Care Quality Commission National Customer Service Centre** **Citygate** **Gallowgate** **Newcastle upon Tyne, NE1 4PA** **3. Skills For Care** **[redacted]** **Information Service Manager** **Skills for Care** **West Gate, 6 Grace Street** **Leeds, LS1 2RP**
1	**CORONER** I am Sean Horstead, Area Coroner, for the coroner area of Essex
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 2nd September 2022 I commenced an investigation into the death of Michael Brian Waite, aged 63 years. The investigation concluded at the end of the inquest on the 8th December 2023. Following a Post Mortem Examination the medical cause of death was confirmed as: *'1a Sudden Cardiac Event, 1b Hypertensive Heart Disease; 2 Diabetes Mellitus'*. I concluded that the this was a *Natural Causes* death.
4	**CIRCUMSTANCES OF THE DEATH**

	Mr Waite had recognised learning difficulties and was a resident, together with two others with learning disabilities, in supported living accommodation provided by Peabody. The three residents were provided with 24-hour support by a sole Support Worker (SW), working shifts. On the late afternoon of the 19th August, 2022 at some point after 17.30 hours, Mr Waite was seen by his SW to be vomiting heavily at the kitchen sink and drinking a significant amount of water. The SW urged him to stop drinking the water and to go into the back garden for some fresh air. The SW accompanied Mr Waite to the garden and returned to the house to clean the kitchen sink and to check on the other two residents. Whilst in the kitchen the SW witnessed Mr Waite collapse in the garden and ran out to him. Mr Waite collapsed in the rear garden of the property and, having relocated Mr Waite from the flower bed into which he had partly fallen to the lawn, he provided some initial CPR before returning to the house to locate his work mobile phone to call for an ambulance. The SW confirmed in evidence that there was delay in his making the call as he had struggled to locate the phone, and then once he found it he returned to Mr Waite but had difficulty accessing the phone as he could not, in the pressure of the moment, recall the passcode. He eventually made contact with the emergency services at 18.14 hours before resuming his attempts at resuscitation. An experienced East of England Ambulance Service Trust (EEAST) paramedic in a Rapid Response Vehicle arrived at around 18.20 hours and, identifying that Mr Waite's cardiac output was asystole and that hypostasis was present (subsequently confirmed by the EEAST Leading Operations Manager attending within minutes), confirmed life extinct. No further CPR was initiated. In my findings and determinations, I recorded that it was likely that time elapsed between Mr Waite's witnessed collapse and the call being made to summon the EEAST was significantly longer that the SW had (honestly) recalled. I made this finding in accordance with the agreed pathology evidence that signs of hypostasis unambiguously confirming death (and upon the basis of which, together with other features, the RRV paramedic did not initiate further CPR) would have required a minimum of 20 to 30 minutes following death to be apparent. I was satisfied that the SW had provided honest though mistaken evidence about the length of time that had elapsed between the collapse and the 999 call, arising in the circumstances and context of the SW's first experience of such a challenging event and the provision of CPR by him.
5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to concern. Although not identified as causative of the death in this case, 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. Although the SW involved in this case had received Basic Life Support training, the evidence of senior witnesses for Peabody, including the Assistant Head of Service and the Director of Care, confirmed that there is presently no requirement for Support Workers, employed by Peabody to provide 24-hour solo support to clients in supported living accommodation, to undergo certificated First Aid Training including Basic Life Support training, *prior to* assuming their role. 2. Whilst it is recognised that residents in supported living accommodation have varying capabilities and varying abilities to care for themselves, as in this case, many will require help and support and, as such, will have varying - including significant - degrees of vulnerability. In my view, for those who are solo providers of support in such circumstances (ie are working alone in providing the support required) to *not* have received formal, certificated First Aid training, including Basic Life Support training, prior to assuming their duties gives rise to the risk of future deaths.
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 Wednesday 27th March 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 and to the following Interested Persons: [redacted], Sister-in-Law of the deceased; Hill Dickinson Solicitors, representing the EEAST; [redacted], EEAST Paramedic represented by 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	 **HM Area Coroner for Essex Sean Horstead** **31.01.2023**