H G Mark Bricknell
Senior Coroner
for County of Herefordshire

6th March 2024

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Care Home Manager, Credenhill Court Rest Home, Hereford.
1	**CORONER** I am Hugh Gregory Mark Bricknell, Senior Coroner for County of Herefordshire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 28 April 2023 I commenced an investigation into the death of John Patrick MacGREGOR. The investigation concluded at the end of the inquest on 28 February 2024. The conclusion of the inquest was 'Narrative' – Mr MacGregor fell at Credenhill Court Rest Home on the 2nd April 2023. Substantive medical intervention did not take place until the 13th April 2023 when he was profoundly unwell.
4	**CIRCUMSTANCES OF THE DEATH** Patient admitted with chest pain and shortness of breath after a fall in a care home. He was found to have a left sided hydropneumothorax, fractured right proximal humerus and L1 end plate compression fracture. A chest drain was inserted and drained well on the ward and he was receiving IV antibiotics. He was reviewed by geriatricians and respiratory physicians, who assisted in optimising his management. He was also reviewed by T&O for his fracture. However, his infection markers did not improve after 7 days of IV antibiotics and IV antifungals. He became significantly more unwell with fluctuations in blood pressure and increasing oxygen requirements. A chest x-ray showed a right sided-HAP. He was already receiving the antibiotic of choice for this with no improvement and a decision was made to start him on the end of life pathway. There was concern regarding the lapse of time from the fall to hospital admission.
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. – Evidence was heard regarding: (a) The quality of residents care documentation and its completion. (b) Procedures regarding escalation or non-escalation following a fall and subsequent medical intervention
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, [redacted], Care Home Manager 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 1 May 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]. I have also sent it to Herefordshire Council and the CQC 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	6 March 2024 Signature HG Mark Bricknell, HM Senior Coroner: Herefordshire