Regulation 28: Prevention of Future Deaths report
Victor Valentine Costello (died 23rd February 2020)

	THIS REPORT IS BEING SENT TO: [redacted] (Chief Executive) Stockton Care Limited Suite 20, Durham Tees Valley Business Centre Orde Wingate way Stockton-on-Tees TS19 0GD
1	**CORONER** I am: Jo Wharton HM Assistant Coroner for Teesside & Hartlepool The Coroner's Office Middlesbrough Town Hall Albert Road Middlesbrough TS1 2QJ
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 13 March 2024, I opened an investigation into the death of Victor Valentine COSTELLO, aged 84. The investigation concluded at the end of the inquest also held on 13 March 2024. I made a determination that death was from natural causes. The medical cause of death was:- • 1(a) bronchopneumonia • 2 cerebral infarction and generalised atherosclerosis
4	**CIRCUMSTANCES OF DEATH** Mr Costello was a resident at Primrose Court Nursing Home. He was taken to hospital on the morning of the 17th February 2020 and passed away there six days later from naturally occurring disease.
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: Mr Costello was nil by mouth and PEG fed. His family raised concerns that Mr Costello had told them he had been drinking water from the taps in his bathroom. Evidence was given at the inquest by the Nursing Home Manager that such concerns were communicated to all staff. However, further evidence given at the inquest showed that such communication was not effective (the nurse in charge and the two care assistants who were on duty on the morning Mr Costello was taken to hospital, all denied being aware of such concerns).
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 the 9th 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:- • **Mr Costello's family** • **The Care Quality Commission.** 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: 14 March 2024** J. Wharton **Jo Wharton** **HM Assistant Coroner for Teesside & Hartlepool**