REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) The Lakes Care Centre 2) Care Quality Commission
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 12th September 2023, I commenced an investigation into the death of Frederick Martin Gerard BOYD. The investigation concluded on the 12th March 2024 and the conclusion was one of Narrative**: Died from the complications of long-term catheterisation contributed to by neglect. The medical cause of death was 1a) Peritonitis 1b) Bladder perforation due to long-term urinary catheterisation II) Paraplegia resulting from injuries sustained in a Road Traffic Collision (2012)**
4	CIRCUMSTANCES OF THE DEATH Frederick Martin Gerard Boyd had a long-term catheter. He was a resident of the Lakes Care Home. He complained of severe abdominal pain on 10th September 2023.He was given pain relief. No observations were taken to assess how unwell he was. During the course of the night there were no formal observations taken. There is no documentation to indicate that effective and regular checks were carried out during the night. On 11th September at about 6am he was found unresponsive in bed. A postmortem found he had died from peritonitis due to a bladder perforation caused by long term catheterisation.

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. – 1. The inquest heard evidence that there was no clear system or expectation regarding the quality of checks on a resident who exhibited signs of being unwell. 2. The evidence before the inquest was that the documentation in relation to the key period was limited and that there appeared to be a limited understanding by staff of the level of detail required and that oversight of the quality of documentation by senior managers was limited. 3. The evidence before the inquest indicated that the system for escalation where a patient was unwell was unclear and not understood by staff.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 27th June 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 namely [redacted] on behalf of the family, 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	**Alison Mutch** **HM Senior Coroner**  **02/05/2024**