Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Happy at Home Community Care Services Ltd.**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Berkshire
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 21 November 2023 I commenced an investigation into the death of Wendy Ann AFFORD aged 87. The investigation concluded at the end of the inquest on 30 August 2024. The conclusion of the inquest was that: Wendy Ann Afford had been bedbound for most of the year prior to her death and suffered from complications arising from this, her age and various medical conditions. Her overall health and skin condition deteriorated from June 2024 and Mrs Afford declined and died on the 15th November 2023 at the Beacher Hall Care Home, Reading.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Afford was discharged to her home from hospital in February 2023 with a package of care to be provided by Happy at Home Community Care Services. She lived alone and was bedbound. She needed personal care and carers attended 4 times per day. She was discharged with a pressure ulcer which had healed by the 4th April 2023.

	In June 2023 she developed pressure damage to her right buttock, this got worse over the course of July and she was admitted to the Royal Berkshire Hospital on the 26th July 2023 with an infected pressure ulcer. Mrs Afford remained in hospital until the 13th September 2023 and by this time she had become more frail. The tissue viability team were involved in her care during her inpatient stay. She was discharged to Beacher Hall Care Home for ongoing care. She still had a pressure ulcer and a referral was made to the community tissue viability nurses who provided advice and assistance to the care home. Mrs Afford's health declined and she died on the 15th November 2023.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. The risk assessment for Mrs Afford in respect of her skin integrity did not record her high risk of developing pressure damage and it was entirely unclear how the risk was assessed in the first place. 2. It is not clear whether body maps were completed as often as required by the carers and therefore there is a concern that they were not monitoring Mrs Affords pressure areas properly. 3. It was not clear whether the carers were properly following the care plan and the records showing whether or not Mrs Afford was repositioned were incomplete. The records that did exist only recorded her position or stated 'repositioned' they did not record whether she was moved, for example, from left to right. The facility within the electronic care record system to highlight the need for carers to reposition Mrs Afford, and record the move, were not used reliably and I heard evidence from a manager which suggested they were not aware of the ability to set repositioning as a mandatory task for each visit. 4. The management of the care company did not appear to carry out audits of records and compliance with care plans nor have any other effective means of oversight. 5. Given these numerous difficulties there is a concern that care staff are not properly trained in the use of care plans, record

	keeping and importance of monitoring skin integrity. This report is not intended as a punitive measure but rather to highlight the areas of concern so that the care company can address them and improve the quality of care for their clients.
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 October 25, 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 **Mrs Afford's family;** **Berkshire Healthcare NHS Foundation Trust;** **Beacher Hall Nursing Home;** I have also sent it to **CQC Legal - Care Quality Commission** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest.

	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: 30/08/2024**  **Robert SIMPSON** **Assistant Coroner for Berkshire**