ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Henning Hall Nursing Home** **2. Springcare Care Homes Ltd**
1	**CORONER** I am Charlotte Keighley, Assistant Coroner, for the coroner area of Cheshire.
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 the 7th February 2024, I commenced an investigation into the death of Victor William Knowles. Victor died on the 20th January 2024. He was 79 years old. The investigation concluded at the end of the inquest on the 12th December 2024. The medical cause of death was confirmed as 1a Osmotic Demyelination Syndrome caused by 1b Hypernatremia due to 1c Dehydration; and 2 Frailty of old age. I recorded a narrative conclusion that Victor died of a rare neurological complication of hypernatremia as a consequence of dehydration and malnourishment and that Victor's death was contributed to by Neglect.
4	**CIRCUMSTANCES OF THE DEATH** On the 12th of December 2023, Victor was admitted to Henning Hall Nursing home as a short-term placement to inform in his long-term care planning. At the time of his admission Victor lacked mental capacity and was identified as being at high risk of dehydration and malnutrition, requiring assistance to promote his fluid and oral intake. Plans were put in place for his weight to be monitored and recorded weekly. The Court heard evidence that on the 2nd January 2024, Victor was seen by his GP and although there was some discussion in respect of his poor dietary intake, the GP was not informed of the 5kg of weight that Victor had lost within the preceding 12 days, nor was the GP provided with the details of the limited amount of fluid that Victor was taking at that time. On the 4th January 2024, Victor was booked onto the GP triage list following concerns being raised by staff in respect of his fluid and oral intake. The Court heard evidence that the GP made three attempts to contact the Home but there was no answer with no follow up being made by the Home in respect of the missed appointment. The Court heard evidence from the GP that Victor was seen again on the 9th January 2024 by which time he had become too frail for his weight to be measured. At the time of the review, Victor's fluid intake was very low but the details recorded by the Home

	were not provided to the GP so as to form part of his assessment, nor was the GP informed that Victor had become too frail to weigh. The Court heard evidence that on the 11th January 2024, Victor was reviewed via telephone by the community dietician who was informed that Victor's weight had been steady since early December but that he was refusing to eat and required encouragement to drink. It was accepted that the information in respect of Victor's weight was not accurate given that he had lost 5kg since his admission to the Home. Later that day, a telephone call was made by the Home to the next of kin, in which it was reported that Victor was very poorly, his clinical observations indicating very low blood pressure and a high pulse rate. Evidence was heard that attempts were made that day to contact both the GP and the Urgent Community Response team, but to no avail with no further steps being taken at that time, to obtain medical treatment for Victor. Overnight, Victor's condition did not improve, it being noted that Victor was very poorly. A call was initially made to the GP at 14.53 hours followed by a request for an ambulance at 15.11 hours. On admission to Hospital, the Court heard evidence that Victor had an acute kidney injury and hypernatremia secondary to being grossly dehydrated and malnourished, with Victor having developed osmotic demyelination syndrome, a rare neurological complication of hypernatremia. Attempts were made to treat Victor, however his condition continued to deteriorate and he passed away on the 20th January 2024.
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 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:- 1. The evidence highlighted that the only internal investigation that took place in respect of the care provided to Victor was in the context of safeguarding and as a consequence of a request from the Local Authority, under section 42 of the Care Act 2014, following the submission of safeguarding referrals by the Hospital after Victor's death. 2. Although an internal review of the care arrangements in place for Victor took place alongside the internal investigation, the purpose of this was to identify any further opportunities to strengthen existing procedures, rather than to identify any areas of learning and improvements that could have been made in respect of Victor's care. 3. The evidence highlighted that there had been little reflection upon the events leading up to Victor's death, with no facility for the identification of any missed opportunities to provide or obtain care for Victor prior to his final admission to hospital. 4. The evidence highlighted that there was no mechanism for lessons to be learned from deaths which occur during or following admission to the Nursing Home.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe your organisations 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 February 2025. 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:- The family of Victor William Knowles East Cheshire NHS Trust Henning Hall Nursing Home I have also sent it to the Care Quality Commission 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	**DATE: 2nd January 2025** **SIGNED:-**