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 Abbey Place Nursing Home**
1	**CORONER** I am Steve ECCLESTON, Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 28 March 2023 I commenced an investigation into the death of Raymond JENNINGS aged 84. The investigation concluded at the end of the inquest on 06 March 2025. The conclusion of the inquest was that: Raymond (known as 'Ray') Jennings died on 07.03.23 at Huddersfield Royal Infirmary from pneumonia. There was a failure to promptly administer antibiotics by his care home but this was probably not causative in his death.
4	**CIRCUMSTANCES OF THE DEATH** Raymond, an 84 year old gentleman was admitted to Huddersfield Royal Infirmary on 19th February 2023, He was diagnosed with sepsis due to community acquired pneumonia Despite medication, Raymonds prognosis remained poor, he was put on palliative care on 24th February and sadly passed away on 7th March 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) Ray Jennings lived at Abbey Place Care Home, 90, Abbey Road, Huddersfield HD2 1BB. He was physically frail and lived with Alzheimer's Dementia Antibiotics for a chest infection were prescribed by Ray's out of hours GP on 16.02.23. The care home made initial attempts to obtain the antibiotics from a pharmacy that evening but failed to achieve this. They did not seek further medical advice or admission to hospital that night. Further unsuccessful attempts were made to obtain the antibiotics the next day. No attempts were made to obtain antibiotics on 18.02.23 nor was further medical advice or admission to hospital sought. By 19.02.23 Ray's condition had deteriorated to the extent that he required hospital admission.

	Despite appropriate treatment in hospital, Ray did not recover and he died on 07.03.23. The medical evidence was clear that, although it could not be said that prompt admission of antibiotics would have probably prevented the need for Ray to be admitted to hospital and/or his death, the failure to either promptly administer the antibiotics or seek further medical care for him was a significant failing on the part of the care home. This was admitted in evidence and was identified as a missed opportunity. Evidence was given by the care home that lessons had been learned and systems improved but no documents were adduced in support of this such that the court could be confident that this issue would not reoccur. For that reason this report is being issued, in particular in relation to the concern that there may be a future risk that other vulnerable residents may not have their need for the prompt administration of prescribed medications met.
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 May 01, 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 **Abbey Place Nursing Home** I have also sent it to [redacted] 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: 06/03/2025** **Steve ECCLESTON** **Assistant Coroner for** **West Yorkshire Western Coroner Area**