REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: BARCHESTER HEALTHCARE LIMITED**
1	**CORONER** I am Andrew Cousins, Assistant Coroner, for the area of Blackpool & Fylde.
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 30 April 2025 and 23 May 2025, at an inquest held at Blackpool Town Hall, I returned a narrative conclusion that Mr Keith Inseon died following a following a choking episode at Blackpool Victoria Hospital, where he was being treated following a fall at the Glenroyd Care Home. I found the cause of death to be: 1(a) Respiratory failure 1(b) Aspiration pneumonia 1(c) Choking episode II Fractured neck of femur (operated on 28.4.24) Coronary artery atherosclerosis.
4	**CIRCUMSTANCES OF THE DEATH** I returned the following in box 4 of the Record of Inquest recorded: Mr Keith Ineson resided at the Glenroyd Care Home, 164 Whitegate Drive, Blackpool, FY3 9HF. It was known that Mr Ineson was at risk of suffering from falls and required an altered diet. On 26 April 2024, Mr Ineson was in the process of mobilising when he suffered an unwitnessed fall. The carer in attendance had left the room and upon their return, Mr Ineson was found on the floor. On 27 April 2024, Mr Ineson was taken to Blackpool Victoria Hospital where he underwent a right hemiarthroplasty. On 3 May 2024, and following the right hip hemiarthroplasty surgery, Mr Ineson suffered a choking episode on food. Mr Ineson developed aspiration pneumonia and, despite treatment, Mr Inseon's condition deteriorated and he died on 6 May 2024 at Blackpool Victoria Hospital.
5	**<u>CORONER'S CONCERNS</u>** 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 Keith Ineson was a resident at the Glenroyd Care Home from 6 June 2019. It was known to the Glenroyd Care Home that Mr Inseon was a high falls risk, and measures had been put in place to address this issue. Following the fall on 26 Aril 2024, I found that the senior carer who checked Mr Ineson for signs of injury had conducted an appropriate assessment. It was noted in the evidence, that the observation scores taken for Mr Ineson following his fall had not all been recorded in Mr Ineson's care notes. This left a gap in the evidence as to reviewing the need for escalation to medical services after the fall. I received from witnesses who gave evidence before me, helpful assistance concerning several issues about learning and changes that had been made following Mr Ineson's death. I could not identify changes to the record keeping system though, and as such found that the issue around the absence of recording observation scores following a fall gave rise to a risk of further death. This was because the record keeping was inaccurate, contained gaps in the information, and engaged my duty under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
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 22 July 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: The family of Keith Inseon Barchester Healthcare Limited 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. She 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.
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Assistant Coroner for Blackpool & The Fylde
Dated: 27 May 2025