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 Marine Lake Medical Practice**
1	**CORONER** I am David LEWIS, Assistant Coroner for the coroner area of Liverpool and Wirral
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 23 September 2025 I commenced an investigation into the death of Gloria SIMON aged 81. The investigation concluded at the end of the inquest on 29 October 2025. The conclusion of the inquest was that: On 9 September 2025 the Deceased moved into Riversdale Care Home, 14-16 Riversdale Road, West Kirkby, Wirral, to achieve some respite for family members who normally provided care for her at home. Her previous medical history included longstanding Chronic Obstructive Pulmonary Disease and Dementia. On 17 September 2025 care home staff sought GP input following concerns about her health, but on learning this was not immediately available they did not seek clinical assistance through the 111 telephone line. None of the care home staff had any clinical qualifications. It is not clear that their training equipped them to deal with this situation appropriately. This resulted in an opportunity to secure timely clinical input being missed. On 19 September 2025 staff were again concerned about the Deceased's health and took basic observations, which revealed very low oxygen saturations, noted to be 84%. An urgent referral to a different GP practice was made, but the GP to whom the case was allocated chose not to visit to assess the Deceased in person, having misread the 84% as 94%, and having failed to note or explore the previous medical history. Based upon his diagnosis of a probable chest infection, the GP prescribed antibiotics, which were administered, but the Deceased's condition deteriorated and she died at the care home the following day from natural causes. The evidence did not reveal whether or not attendance by a GP (on either 17 or 19 September 2025), closer monitoring by care home staff or admission to hospital would have been likely to change the outcome.
4	**CIRCUMSTANCES OF THE DEATH** On 9 September 2025 the Deceased moved into Riversdale Care Home, 14-16 Riversdale Road, West Kirkby, Wirral, to achieve some respite for family members who normally provided care for her at home. Her previous medical history included longstanding Chronic Obstructive Pulmonary Disease and Dementia. On 17 September 2025 care home staff sought GP input following concerns about her health, but on learning this was not immediately available they did not seek clinical

	assistance through the 111 telephone line. None of the care home staff had any clinical qualifications. It is not clear that their training equipped them to deal with this situation appropriately. This resulted in an opportunity to secure timely clinical input being missed. On 19 September 2025 staff were again concerned about the Deceased's health and took basic observations, which revealed very low oxygen saturations, noted to be 84%. An urgent referral to a different GP practice was made, but the GP to whom the case was allocated chose not to visit to assess the Deceased in person, having misread the 84% as 94%, and having failed to note or explore the previous medical history. Based upon his diagnosis of a probable chest infection, the GP prescribed antibiotics, which were administered, but the Deceased's condition deteriorated and she died at the care home the following day from natural causes. The evidence did not reveal whether or not attendance by a GP (on either 17 or 19 September 2025), closer monitoring by care home staff or admission to hospital would have been likely to change the outcome.
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 GP to whom this case was allocated told the court that he did not know that Gloria Simon was in a care home setting (as opposed to a nursing home setting), which had no clinical staff of any kind, despite having previously visited the premises and despite the clerical assistant's note on a Consultation Report that this was a request from 'CH'. He indicated that it was as a result of this misunderstanding was that he did not visit the premises to make a face-to-face clinical assessment. The court is concerned that a recurrence of this situation could leave vulnerable elderly patients with inadequate care. The court would like to know whether measures are being taken to ensure that those in the practice are properly informed about the nature and status of resident institutions with whom they have contact. 2. In its typed 'Request for Care' form, the care home noted that Gloria Simon's oxygen saturations were 84% and described them (correctly) as 'very low'. The time when the observations were taken was not stated. Despite a clerical assistant at the GP practice having noted down correctly that the reading was 84%, the GP misread the papers as saying 94% and described the oxygen saturations as 'low'. The GP told the court that he would have been assisted by knowing the patient's previous medical history and would have acted differently had he known it. However, the records indicate that this information had been supplied by the care home, had been flagged by another GP who made a record on the practice's system, and was available to him. There was no evidence before the court to suggest that the GP had: (a) requested sight of the previous medical history, or made any enquiry about it when (or before) he spoke to a member of staff at the care home; or (b) asked when the observations had been taken or recommended that any further observations should be taken; or (c) asked about whether those observing or caring for the Deceased had any clinical qualifications (having assumed, incorrectly, that she was in a nursing home setting). The court considers that this elderly vulnerable patient should have had a face-to-face clinical assessment but did not because of insufficient attention to detail and/or clinical curiosity on the part of the GP. The court would like to understand how the practice can ensure that this is not something that will recur.

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 December 26, 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 [redacted] I have also sent it to [redacted] **Riversdale Care Home** 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. They may send a copy of this report to any person who they believe 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: 31/10/2025** [redacted] **David LEWIS** **Assistant Coroner for** **Liverpool and Wirral**