



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 Riversdale Care Home
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 death was from natural causes.
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 email sent to the GP practice with the 'Request for Care' form noted the sender's email address to be [REDACTED] (RIVERSDALE NURSING HOME, WIRRAL). On the form itself, the box in which the sender was asked to identify the staff involved in the case was completed with the words 'Riversdale Nursing Home', which was its name before it changed from a nursing home to a care home in 2023.

The GP to whom the request was passed for action told the court that he believed that the Gloria Simon was resident in a nursing home setting, and that he would have acted differently (by making a visit to see her in person) if he had known that it was in fact a care home setting, with no clinically qualified staff members on site.

The court is concerned that this preventable misunderstanding contributed to a vulnerable elderly resident being left without a face-to-face clinical assessment (which would have been likely to result in a different approach to care and management) and would like to know what measures are being taken to address this.

2. On 17 September 2025 the staff at the care home were sufficiently concerned about the Gloria Simon's health that they sought assistance from her registered GP, who declined to visit because she was no longer within their area. Whilst efforts were made to register her with a practice local to the care home, staff did not make any alternative arrangements for obtaining clinical input in the meantime. The court heard that staff should have called 111. Depending upon the seriousness of their concerns, another possibility would have been to call 999. In fact, no further attempt was made to seek help until 14:52 on 19 September 2025.

The court is concerned that the training of non-clinical staff was insufficient to equip them with knowledge about how to manage a situation such as this effectively and would like to know what measures are being taken to address this.

3. It was not clear from the evidence that the staff at the care home have been trained so that they have a sufficient understanding of when basic observations should be taken, how and where the results should be recorded or how they should be acted upon.

There was no evidence that observations has been carried out prior to 19 January, despite Gloria Simon having been judged sufficiently unwell on 17 January that a GP should be called. The court was not made aware of when the observation results contained in the Request for Care form had been taken, nor whether further observations were taken at all in the period of more than 24 hours between then and her death.

The court is concerned that the training received by care home staff did not enable them to understand the potential value and importance of basic observations, nor to understand how they should act upon them, thereby denying them (and clinicians who might be involved later) information which might assist in determining the seriousness and evolving nature of the condition of an elderly and vulnerable resident. The court would like to know what measures are being taken to address this.

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] 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