	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Manager, The Manor Residential & Nursing Care Home, 78-80 Lutterworth Road, Aylestone, Leicester, LE2 8PG**
1	**CORONER** I am Catherine Mason senior coroner, for the coroner area of Leicester City and South Leicestershire
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 9th October 2012 I commenced an investigation into the death of Joan Mary Jones. The investigation concluded at the end of the inquest on 18th September 2013. The conclusion of the inquest was that the cause of death was Bilateral bronchopneumonia due to locally advanced adenocarcinoma of the large bowel and Alzheimer's dementia. A narrative conclusion was recorded as follows: On the 23rd September 2012 Mrs Jones became unwell and was seen by an out of hours doctor who diagnosed a viral infection. No further concerns were raised until the 30th September 2012 when she became unresponsive following an episode of aspiration the previous day. Again an out of hours practitioner attended. Mrs Jones thereafter continued to deteriorate and she died on the 1st October 2012 at The Manor and Residential Home, Leicester. Medical opinion is that when Mrs Jones initial illness had not showed signs of improvement after 2 to 3 days her General Practitioner should have been notified and it is likely that antibiotics would have been prescribed. This did not happen. As a result there was a missed opportunity to treat. However, medical evidence is that it is unclear whether the outcome would have been different.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Jones was a resident at The Manor and Residential Home, Leicester and was known to have Alzheimer's dementia. An out of hours doctor saw her on the 23rd September 2012 because the professionals caring for her were concerned about her being unwell. The doctor found her to have a runny nose and a slight cough. All vital signs were within normal range and a viral upper respiratory tract infection was diagnosed. Medication was not considered necessary and advice was given to encourage fluids and report any deterioration or further concerns. Mrs Jones continued to be cared for at the Home. On the 30th September those caring for Mrs Jones sought assistance from an out of hours advanced nurse practitioner. When he attended he observed that Mrs Jones had cold like symptoms and again considered them to be viral in nature. He noted a low blood pressure but was not concerned with it of itself. However, evidence revealed that he was not told of the doctor's visit the week before nor of the vital signs recorded at that stage. In addition, he was not infirmed of the aspiration. He said if he had he thought it was likely that he would have made arrangements for Mrs Jones to be admitted to hospital rather than instruct that she should remain at the Home. A Doctor from the practice that Mrs Jones was registered at, said that she would not necessarily have admitted Mrs Jones to hospital had she been faced with the same situation, but gave evidence that when Mrs Jones had not showed signs of improvement after 2 to 3 days following the medical attendance on the 23rd September 2012, she would have expected the Home to have contacted the practice and a doctor would have

	visited. Furthermore, she stated that in her professional opinion, with the knowledge of Mrs Jones' dementia and the care home setting, antibiotics would have been prescribed. However, she was not able to say whether on a balance of probabilities the outcome would have been different. However, she was clear in saying that there was a missed opportunity to treat and communicate with Mrs Jones' family and discuss an advanced care plan.
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 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. – (1) The staff did not escalate Mrs Jones' care when they should have done (2) The staff did not communicate all that was known to them and therefore attending health care professionals were unable to make fully informed decisions (3) Due to the lack of communication, an appropriate package of care was not put in place for Mrs Jones (4) These omissions (failure to escalate and the lack of communication with other attending health care professionals) together or alone, could in future circumstances cause or contribute to death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 the 15th November 2013. 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 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	**20th September 2013**