Table 2. The 31 coroners' PFD reports that were sent to CQC – nature of coroners' concerns and interval before subsequent inspection by CQC

Name of deceased	Nature of coroners' concerns	The PFD was directly addressed to CQC	Interval between PFD and subsequent CQC inspection
Malcolm BENNETT	No ambulance called after patient attacked and injured	No	Missing data
John BIRD	Poor management of falls and staff training issues	No	1 month
George BROWN	Fall. Rapidly deteriorating patient not moved to a more suitable care facility despite a request by the home	No	8 months
Gwendoline CLARKE	Multiple injuries and reports by the patient that a member of staff had hurt her. Not reported to the police, delay in calling an ambulance.	Yes – addressed to David Behan CQC CEO	2 months
Dorothy CLARKSON	Failure to manage choking risk, staff training. Neglect.	Yes	5 months
Violet CLOUDSDALE	Fall. Use of wheelchair lap belts.	Yes	No evidence of inspection since PFD issued 12 months ago
Barbara COOKE	Two Grade 4 pressure sores. Neglect. Lack of staffing.	Yes	6 months
Norman DORN	Choking. Lack of arrangements to ensure appropriate CPR and confirmation of death.	Yes	4 months
Thomas FARRELL	Poor medicines management. Care home did not ensure patient received all prescribed medication.	No	1 month
Beryl FRENCH	Failure to carry out CPR. Confusion over records. Inadequate arrangements for end of life care.	No	No evidence of inspection since PFD issued 29 months ago

Harold GOULDING	Failure of medicines management and communication between professionals.	No	No evidence of inspection since PFD issued 3 months ago
Lillian HURSELL	Unreliable cot sides and a related heavy fall.	Yes	6 months
Janine KAISER	Care plan for managing pressure ulcer not followed. Records falsified after death.	No	2 days
Marjorie KEOGH	Fall. Failure to assess risk.	No	17 months
Doreen MATTINSON	Failure to use oxygen equipment properly. Staff training.	No	No evidence of inspection since PFD issued 6 months ago
Margaret METCALFE	Fall. No staff response to an alarm buzzer.	No	2 months
John MORRIS	Death after absconding and wandering on a winter night. Insufficient staffing at night.	Yes	4 months
Peter PATTINSON	Fall, failure to respond to family requests to raise bed rails. Missing records entries.	No	3 months
Walter POWLEY	Deep burns after fall against a radiator set at a higher temperature than HSE guidance allows. Radiators and valves not covered at this home and other homes in the area. The coroner was concerned about whether this was a pattern nationally.	Yes – addressed to David Behan CQC CEO CQC's response to the PFD is published.	12 months
Derrick RIVERS	Poor medicines management and non-adherence to protocol. Patient given medication meant for another patient. The CQC had not inspected medicines management in the most recent inspection before the death.	Yes – addressed to David Behan CQC CEO	3 months
James ROBERTSON	Poor record keeping and failure to demonstrate that	Yes	5 months

	checks had been carried out according to the care plan. Potential delays in administering CPR as staff needed to check CPR status in an emergency. Resuscitation pack did not include a suction tube and the coroner suggested there should be a national standard on what is contained in resuscitation packs.		
Christopher ROYAL	Failure to provide first aid when the patient collapsed. Observations had not been carried out or reliably and correctly recorded. Lack of staff training and long shifts.	No	No evidence of inspection since PFD issued 26 months ago.
Maria SILKIN	Repeated falls. Inaccurate risk assessment that failed to note that the patient had been falling. Delay in taking the patient to hospital.	No	7 months
Vincent SMITH	Poor management of repeated falls. Processes for assessing residents' suitability for this unit required review.	No	No evidence of inspection since PFD issued 6 months ago
Vera STEEL	Management of fire risk due to smoking. Coroner asked CQC and HSE to consider introduction of fire aprons, now available.	Yes	1 month
Pamela THURSTON	Choking after failure to supervise eating. The patient had been given food for 17 hours, and ate quickly because she was hungry.	No	1 month
William TOLEN	Cellulitis (infection) after a toenail was removed. Delay in arranging podiatry. Insanitary conditions. Poor record keeping. No investigation undertaken	No	11 months

	after the death.		
John TUGWELL	Death after repeated falls. Poor risk management and supervision.	No	27 months
Mary WALDRON	Inadequate and slow response to a physically deteriorating patient. Staff training. Failure to investigate after the death. Inaccurate reporting by the home to the CQC. The coroner was concerned that it was not clear what investigation the CQC would undertake.	Yes There is no published CQC response to the PFD report on this case	22 months
Stanley WARD	Death after a fall, with head injury exacerbated by anti-coagulant treatment. Lack of guidance for staff on the added risk to anti-coagulated patients, and unclear processes for arranging medical review.	Yes There is no published CQC response to the PFD report on this case	7 months
Olive WILMOTT	Death after a fall. Failure to carry out planned checks. No Safeguarding response to a report that the patient may have been pushed.	No	No evidence of inspection since PFD issued 3 months ago.