REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used after an inquest.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS.

THIS REPORT IS BEING SENT TO:

The Heathers Nursing Home 50 Beccles Road Bradwell Great Yarmouth Norfolk NR31 8DQ

1 CORONER

I am Jacqueline Lake, senior coroner/area coroner/area sistent-eerener, for the coroner area of Norfolk.

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 5th August 2013 I commenced an investigation into the death of MARGARET CONNOR, AGE 91 YEARS. The investigation concluded at the end of the inquest on 8th May 2014. The conclusion of the inquest was medical cause of death: 1a) Bronchopneumonia 1b) Dementia Part II Periprosthetic fracture of right tibia, and narrative conclusion "Natural causes contributed to by a fracture to the right tibia which probably occurred on 3.7.2013 and which went undetected until admitted to hospital and an x ray was performed on 12.7.2013"

4 CIRCUMSTANCES OF THE DEATH

Mrs Connor was a resident in Heathers Nursing home. On 3.7.2013 she was seen by a carer in a wheelchair where the footplate was misplaced to one side, although the evidence was that Mrs Connor's leg and foot were not in an abnormal position. There was further evidence that the footplates are sometimes loose and not fitted properly (as in this instance), do not match and are not the right footplates for a particular wheelchair. It was accepted on behalf of the Nursing Home this is when Mrs Connor probably suffered a fracture to her right leg. During the course of the next few days Mrs Connor was noticed to have a lump to her knee, pain, swelling and increased bruising. Doctors were called out but were told there had been "no trauma" to her right leg. Mrs Connor was admitted to Hospital by a GP on 12.7.2013. An x ray was carried out on 13.7.2013 which showed a fracture. Mrs Connor's condition continued to deteriorate and she died on 2.8.13. The Post Mortem Report comments "The debility caused by the recent fracture is likely to have contributed to the death".

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) Insufficient procedures are in place to check wheelchairs before use. Carers collect a wheelchair from an alcove and are required to check over before it is used. It would appear this is not always being done.
- (2) Wheelchairs are left in the alcove ready for use without footplates, loose footplates and mismatched footplates.
- (3) There are insufficient/no independent checks being carried out on wheelchairs on their return to the alcove. They are only referred to "the maintenance man" if there is something noted to be wrong with them.
- (3) The attending Doctors were being told there had been "no trauma" to Mrs Connor's leg, despite concerns being raised by her family that her foot/leg had been injured on the wheelchair and despite the faulty plate having been seen by staff.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe 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 4 July 2014 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 Person:



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 9 May 2014

