HER MAJESTY'S CORONER
for the county of West Yorkshire
(Eastern District)

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Our Ref: DH/CS/2788L/12
Please quote our reference on all correspondence

1 August 2013

FAO Darren Gibson
The Chief Executive
Saga Homecare
Beaconsfield Court
Beaconsfield Road
Hatfield
Hertfordshire
AL10 8HU

Dear Mr Gibson

Inquest touching the death of Annie Rose GIBSON (deceased)

I concluded the Inquest touching the death of the above named in my Wakefield Court on 24th July 2013, at the conclusion of which I made an announcement pursuant to Rule 43 of the Coroners (Amendment) Rules 2008, and I am reporting this matter to you in accordance with that Rule.

In order to assist you this Rule provides that where the evidence at an Inquest gives rise to a concern that circumstances creating a risk to others will occur or will continue to exist in the future and in the Coroner's opinion such action should be taken to prevent the occurrence or continuation of any such circumstances or to eliminate or reduce the risk of death created by such circumstances, the Coroner may report the circumstances to a person who may have power to take such action.

In accordance with Rule 43 a copy of this Report is being sent to the Chief Coroner. Your response to this Report can be shared with other Properly Interested Persons. The Chief Coroner may send a copy of the Report and responses to any person whom he believes may find it useful or of interest. In addition the Chief Coroner may publish a full copy of the summary of the Report and responses.

Please note that Rule 43(A) requires that you give written response within 56 days of the day the Report is sent. If you are unable to respond within that time you may apply to me for an extension. The response is to obtain details of any action that has been taken or which is proposed will be taken, whether in response to this Report or otherwise, or an explanation as to why no action is proposed.

If there are circumstances where you do not want your response to be shared with, or for a copy of it to be published, you may make written representation to me at any time of giving your response. Instead of releasing or publishing your full response it may be possible to share or publish a summary in accordance with Rule 43(A).

The circumstances of Mrs Gibson's death are that she was a widowed lady aged 84, who lived alone at [redacted] Horbury, Wakefield. Mrs Gibson was attended on

a daily basis by her family and home carers from your organisation. This lady was last seen alive between 1133 hours and 1210 hours on Friday 12th October 2012. Mrs Gibson had suffered a fall earlier that day, which had caused her to sustain a large bruise to her forehead. Mrs Gibson explained this saying that she had fallen whilst placing rubbish in her bin and had struck her head. At 1134 hours on Saturday 13th October 2012 a carer, your employee [redacted] visited Mrs Gibson, to discover her kneeling on the floor in her living room partially clothed and in an unresponsive state. An ambulance was called, paramedics attended who confirmed her death at 1154 hours on 13th October 2012.

A post mortem examination gave the cause of death to be :-

1(a) Hypothermia
(b) Immobility
(c) Fractured pelvis and haemorrhage

At this Inquest I recorded a Verdict of Accidental Death. I also recorded :-

> "Annie Rose Gibson has fallen at her home address, 53 Park Street, Horbury, Wakefield on or around 13th October 2012 sustaining a fractured pelvis and associated haemorrhage, hypothermia has also developed, causing her death to be confirmed there at 1154 hours on 13th October 2012".

At the Inquest I was told that Mrs Gibson had been visited by your employee, [redacted] at 1130am on Friday 12th October 2012. Your care worker noted that Mrs Gibson had a bruise to her head caused by a fall earlier that day. [redacted] helped Mrs Gibson downstairs. Mrs Gibson was understandably upset and shaken, but emphatically opposed your carer's desire to call either a doctor or to obtain an ambulance. Mrs Gibson's family concede that she was a very independent lady who would robustly have refused help in this way. [redacted] attempted to contact Mrs Gibson's daughters on various telephone numbers known to your organisation, but there was no response. Mrs Gibson was in fact more concerned that her family attend than obtaining any medical help. Mrs Gibson was left alone when it was not possible to make contact with her relatives.

My recommendations are that you should address situations such as this in your training protocols and Care Plans to ensure that your carers would always, notwithstanding the wishes of your client, call the Emergency Services and ensure ambulance attendance. I also recommend that the wishes of the client would have to be overridden in such a situation, in particular when relatives cannot be contacted.

I believe that had Mrs Gibson been taken to hospital by ambulance when she was found it was likely that her fracture would have been diagnosed and treated. Hypothermia would not have developed and I consider that this death could have been avoided.

I would appreciate your response within the time limit stated.

I enclose for your assistance the statements of your employees, [redacted] and [redacted] which were produced at the Inquest.

If I can provide you with any additional information please let me know.

Yours sincerely

DAVID HINCHLIFF
Senior Coroner
West Yorkshire (Eastern)

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