REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. BUPA Care Homes, Stuart Fletcher, Chief Executive Officer, Bupa House,15 - 19 Bloomsbury Way, London, United Kingdom, WC1A 2BA** **2. [redacted] Legal Administrator, Legal Team, Bupa UK Provision, UK Market Unit, Bridge House, Outwood Lane, Horsforth, Leeds, LS18 4UP**
1	**CORONER** I am Nadia Persaud, Senior Coroner, for the Coroner area of the Eastern District of Greater London.
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made .
3	**INVESTIGATION and INQUEST** On 1st August 2013 I commenced an investigation into the death of Roy Joseph Godfrey. The investigation concluded at the end of the inquest on the 25th March 2014. The conclusion of the inquest was a narrative conclusion: Mr Godfrey suffered a fall at his residential care home on the 23rd July 2013. Paramedics attended and following their assessment, hospital attendance was considered not to be necessary. Mr Godfrey underwent basic checks by staff at the home overnight and no concerns were raised. The following morning he woke around 04.30 and was alert and orientated. Around 07.30 he was noted to be unresponsive. He was admitted to the Queens Hospital where it was found that he had suffered a devastating head injury, from which he died. The head injury is likely to have been caused by the fall on the 23rd July 2013 and Warfarin therapy is likely to have exacerbated the bleed.
4	**CIRCUMSTANCES OF THE DEATH** (1) Mr Godfrey was a 71-year old resident of the Seabrook Manor Residential & Nursing Home. He had a past medical history to include atrial fibrillation and DVT's. As a result of this he was on long term warfarin. On the 23rd July 2013 he suffered an un-witnessed fall at the residential care home. It appears he may have slipped off his bed and knocked his head on a bedside cabinet. An external head injury was noted. There was minimal bleeding from the laceration, but a swelling was seen to be present. He was assessed by a Registered General Nurse who then called for the London Ambulance Service. The paramedics attended and spent around one hour with Mr Godfrey. They performed neurological assessments to include the PEARL Test and GCS assessment. The tests did not reveal any neurological sequelae. The paramedic did however advise the care home staff to observe the patient throughout the night for any signs of increased swelling, lethargy/vomiting or any signs of deterioration. He advised staff to call 999 if there was any sign of deterioration. The staff at the home accepted responsibility of Mr Godfrey. The senior care worker confirmed in her evidence, that she understood the paramedic's direction. She gave evidence to confirm that she took the blood pressure on a

	couple of occasions and thereafter simply observed to see that he was breathing. She did not conduct any neurological observations and did not observe the head injury for any increased swelling, as directed by the paramedic. The following morning Mr Godfrey awoke at the usual time for him (04.30) and appeared alert and orientated. He was taken to the lounge where a few hours later he was noted to be unresponsive in his chair. There was no evidence of any observations of him between 0430 and 0730, when he was found unresponsive. The LAS were again called and he was taken to the Queens Hospital where a CT scan confirmed a large right-sided subdural haematoma. There was a midline shift of the brain and brain herniation. The brain injury was deemed to be fatal and no neurosurgical intervention was considered appropriate. Mr Godfrey passed away at 22.28 on the 24th July 2013.
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. Mr Godfrey was an elderly patient who was at risk of falling and who was on long term warfarin. There is an increased risk of bleeding to elderly patients on warfarin who sustain a head injury. Neither the care staff who attended to Mr Godfrey on the evening of the 23rd July 2013 or the paramedic appeared to have been aware of the increased risk of such bleeding in an elderly patient who had sustained a minor head injury. The inquest heard clear evidence from the London Ambulance Service in relation to further training that was to be provided to their staff in relation to this risk. In addition, amendments are to be considered to the LAS guidance, to highlight this risk to all staff. 2. The staff at the care home accepted the responsibility of Mr Godfrey's care following the paramedic's assessment. They agreed to observe Mr Godfrey during the night. The actual checks carried out by the staff were not in accordance with the direction given by the paramedic. The senior care worker confirmed that she did not examine the swelling or check for alertness. 3. The Deputy Manager who gave evidence at the inquest confirmed that the checks carried out by the staff were not in her view appropriate. She would have expected the pupils to have been checked and checks to ensure that the patient was alert and orientated. 4. The Deputy Manager who gave evidence confirmed that the checks that were carried out on Mr Godfrey were not appropriately recorded in the clinical records. 5. The Deputy Manager confirmed that the qualified member of staff who attended when Mr Godfrey sustained his fall should have been aware of the increased risk of bleeding as a result of the long term warfarin. She confirmed that he may not have had access to the medication chart. It is my view that a qualified member of the nursing staff who attends a patient who has suffered a fall should make themselves aware of both the patient's medical history and medication history. 6. The Deputy Manager considered that it would be helpful for the training relating to falls, prevention and management to include the highlighting of the risk of bleeding in elderly patients who are on anti-coagulant medication. She confirmed that most of the patients at Saxon House are elderly and at risk of falling. She confirmed that some are also on anti-coagulant medication. 7. I heard a great deal of evidence from the London Ambulance Service in relation to a thorough investigation they had conducted into this case. They had the assistance of an independent clinical advisor and had identified all of the relevant issues. They had taken all of the action required to address those issues. BUPA Care Homes however had provided a one page document headed "Summary of Investigation". This was the only investigation document

	8. I note that the BUPA Care Homes Falls Prevention and Management Policy is due for a review in May 2014.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 26th May 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 Persons – [redacted] and the London Ambulance Service. 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	**[DATE]** **[SIGNED BY CORONER]**