REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) [redacted] - Manager, St. Mary's Nursing Home, Harborough Magna, Rugby** **(2) Care Quality Commission** **(3) Nursing and Midwifery Council** **(4) West Midlands Ambulance Service, NHS Foundation Trust**
1	**CORONER** I am R Brittain, Assistant Coroner for Coventry
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** Mary WALDRON died on 24 August 2013, aged 76 years old. An investigation into her death was subsequently started, as ordered by the Chief Coroner. The investigation concluded at the end of the inquest on 23 December 2013. The conclusion of the inquest was narrative [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Mary Waldron died on 24 August 2013 at University Hospital, Coventry, having been transferred from St Mary's Nursing Home that morning. She had been a resident of the nursing home since 19 August and had become unwell at approximately 6.30am on the 24th. Following an episode of vomiting a nurse [redacted] requested an out-of-hours GP visit. Observations were taken by that nurse only after an initial phone call to the GP service. A low blood pressure was recorded. This observation was reported to the out-of-hours triage nurse in a subsequent telephone conversation. A GP visit, rather than an emergency ambulance request, was arranged as a consequence of the discussion between the triage nurse and nursing home nurse. An ambulance was urgently requested only after the attendance of the out-of-hours GP. During transfer from the nursing home to hospital, Mary Waldron suffered a cardiac arrest. Only basic life support was undertaken as no venous access could be obtained. There was confusion between the ambulance driver and paramedic as to how long the transfer to hospital would take, following the cardiac arrest. The driver reported a time of 15 minutes; the paramedic understood the transfer time to be 5 minutes. Basic life support was continued until arrival at the hospital, where death was pronounced. On the evidence of the paramedic, he would have made the same decision (to continue with the basic life support

	and onwards transfer) had he known the correct transfer time.
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) failure of the nursing home staff to recognise an acutely unwell resident; (2) failure of the nursing home staff to undertake appropriate action when they were aware of the low blood pressure; (3) a lack of ongoing training with regard to the recognition and treatment of acutely unwell residents; with reliance solely on initial nursing training; (4) failure of the nursing home managers to undertake an effective investigation into this incident and to take action to prevent repetition; (5) inaccurate reporting by the nursing home managers to the Care Quality Commission (CQC) that internal protocols had been appropriately followed, when evidence given at the inquest was that this was not the case; (6) lack of clarity as to the investigation that is to be undertaken by the CQC. The nursing home gave evidence that the investigation is closed, whilst the family believe it is ongoing; (7) the nurse primarily involved in this incident is no longer an employee at St Mary's and is working elsewhere. St Mary's nursing home is therefore unable to take action to address potential future risks relating to the training of this nurse; (8) the potential for further incidents of confusion between driver and paramedic with regard to hospital transfer times, with the possibility of significant adverse consequences. Evidence given was that satellite navigation information (including time to arrival) was only available directly to the ambulance driver. Direct visualisation of a satellite navigation console by the non-driving paramedic could address this risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the addressees have the power to take such action. (1) St Mary's Nursing Home - Matters of Concern 1-5 (2) Care Quality Commission - Matter of Concern 6 (3) Nursing and Midwifery Council - Matter of Concern 7 (4) West Midlands Ambulance Service - Matter of Concern 8
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 8 March 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 (a) The [redacted] Family, (b) Harmoni Out-of-hours GP service and (c) [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	**10 January 2014** **Assistant Coroner R Brittain**