REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Andrew Worsley, CEO Harbour Healthcare, CQC, Ann Barnes, CE Stockport NHS Foundation Trust**
1	**CORONER** I am, Anna Morris Assistant coroner, for the coroner area of South Manchester
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 31/10/2016 I commenced an investigation into the death of Michael Bingham. The investigation concluded at the end of the inquest 26th July 2017. The conclusion of the inquest was On the 22nd September 2016 the deceased exited through an internal door on the first floor Hilltop Court Care home and fell down stairs. His fall was as a direct result of the emergency door release being activated, which caused all the internal secure doors within the home to release. I find that the fact that the home staff had no way of knowing that the emergency door release had been activated or which doors were insecure also contributed to his ability to exit through the door and therefore to his fall. As a result of his fall, the sustained a fracture to his C1/C2 vertebrae. On attendance at Stepping Hill Hospital on the 22nd September 2016, the Emergency Department Guidelines required that consideration be given to subjecting those over 65 with a suspected head injury a CT scan. On clinical examination, the Doctor decided not to order a CT scan. As a result of a scan not being done on this date, the fracture on the CT1/ CT2 vertebrae was not diagnosed and he was returned to the care home. Had the fracture been identified on the 22nd September the deceased would more likely than not have remained in hospital, been fitted with an orthopaedic collar and intensively nursed in a manner that would have sought to reduce his risk of contracting infection due to immobility or positioning. I find on the balance of probabilities that the fact that the deceased had undiagnosed fracture impacted on his spinal cord and affected his respiration and ability to swallow, which caused him to aspire matter on or after the 23rd September, which then caused pneumonia to develop. On re-admission to Stepping Hill Hospital on the 24th September 2016 his pneumonia had advanced to the degree that when he was examined at 17:50 he had strident breathing and he had become unresponsive. End of life care was put in place and death was confirmed at 20:15. 1a) Aspiration pneumonia 1b) Fracture of C1/C2 vertebrae 1c) Fall 2) Vascular Dementia, Coronary artery atheroma
4	**CIRCUMSTANCES OF THE DEATH** See above
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. –

Harbour Healthcare:

The evidence that I heard was that it is your responsibility as the Registered Person under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to comply with those Regulations. I understand that at present, the Guidance issued by the CQC in respect of those provisions (the Guidance on Providers to meeting the Regulations) does not stipulate how you must comply but does advise that any security provisions must make sure that people are safe whilst receiving care and that premises must be fit for purpose in line with statutory requirements.

It was accepted by you during the inquest that there was a 'blind spot' in the risk assessment of the internal secure doors, in that you were not required by any regulatory body to have an alarm to alert staff when secure doors became insecure by virtue of the use of the green emergency door release or otherwise.

I accept that you have now implemented an alarm system in Hilltop Court Care home that will indicate when the internal doors become insecure and have fitted auditory alarms in relation to the external doors. You indicated that you are in the process of implementing similar systems in the other care homes owned by Harbour Healthcare. I am concerned that without the implementation of these alarms across your service provision there would continue to be circumstances that create a risk of other deaths. I would be grateful for an indication of when you expect this implementation to be completed by way of response.

CQC:

The evidence that I heard was that under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 it is the Registered Persons responsibility to comply with those Regulations. I understand that at present, the Guidance issued by the CQC in respect of those provisions (the Guidance on Providers to meeting the Regulations) does not stipulate how they must comply with those Regulations but does advise that any security provisions must make sure that people are safe whilst receiving care and that premises must be fit for purpose in line with statutory requirements.
I accept that on the present Regulations it is for the Registered Person to make a risk assessment in relation to internal secure doors and the safety and security that they provide to service users. However, I ask you to review, in light of the evidence I have received in the course of this investigation whether there should be a further issue of regulations or guidance to ensure a consistent approach in respect of the assessment of any safety risk due to falls posed by the use of an emergency door release panel. I also ask you to review your inspection procedures in respect of a Registered Person's compliance with the Regulations in respect of the safety and security of internal secure doors.

Stockport NHS Foundation Trust:

I am concerned that the current Guidelines for Head/neck injuries (as amended) may continue to provide a lack of clarity as to when CT scans should be considered in those over 65 and with dementia or other cognitive impairment. The word 'confusion' remains under the general guidance (bullet point 5) but has been changed to 'dementia' under the guidance for those who are already being subject to a head scan. I ask that you consider reviewing your guidelines to ensure clarity and consistency of their clinical application.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 25th September 2017. 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 namely [redacted] son of the deceased, who may find it useful or of interest. 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	**31/07/2017** **Anna Morris** **Assistant Coroner South Manchester**