Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Rt Hon Jeremy Hunt MP** **Secretary of State for Health and Social Care** and **HC-One**
1	**CORONER** I am Derek Winter DL, Senior Coroner for the City of Sunderland
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** Ms Patricia Ann Heslop (Patricia), aged 75 years, died on 9th April 2017. Patricia had been immobile due to vascular dementia and a fracture, which led to a chest infection. The Inquest, as part of my Investigation, concluded on 26th March 2018, when I recorded a narrative conclusion 'Patricia Ann Heslop died from a combination of natural causes and the consequences of an unwitnessed fall'. The Cause of Death following Post-Mortem Examination was: - Ia Acute Bronchopneumonia II Vascular Dementia and Fractured Right Neck of Femur
4	**CIRCUMSTANCES OF THE DEATH** Patricia suffered with dementia and was a resident at Hebburn Court Care Home in the ownership of HC-One. Patricia was a prolific walker, who spent hours walking around the home, and after such exertions she would need to rest. Patricia mobilised independently. This included getting out of her chair and bed without assistance, but she had not been mobilising between 9th and 15th November 2016. Patricia had a fall and had to go to hospital on 15th November 2016. Patricia had sustained a minimally displaced right intracapsular fractured neck of femur. The standard treatment was surgery, which took place on 16th November 2016 so as to

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	lessen pain and facilitate her early mobilisation to minimise the complications of prolonged bed rest. The majority of such injuries are due to low energy trauma with the most common cause being a fall from a standing height. Sadly Patricia's immobility due to her vascular dementia and the fracture led to an acute bronchopneumonia and her death.
5	**CORONER'S CONCERNS** Although HC-One has conducted extensive enquiries and were sincere in their desire to learn lessons, I asked them to revisit those enquiries after the Inquest, including the following concerns: 1. The fall was unwitnessed and went unreported. 2. There appears to have been a change in Patricia's presentation and a number of factors, which were not collated in the days preceding her hospital admission including: • the unusual and regular use of a wheelchair; • the rocking manoeuvre by two members of staff to get Patricia from her chair; • the fact that two members of staff would walk with Patricia. These matters were not recorded, as they ought to have been, nor were the family informed, as they should have been. It is important that family members have confidence in the provision of care to a loved one and have regular information provided to them. 3. A number of terms were used about Patricia's developing condition: "lethargy", "mobility fluctuating", "gone off her feet", "struggled to stand" and "non-weight bearing", yet no significance was placed upon what this really meant alongside an effective early warning system associated with observations. 4. There was evidence that care plans had not been updated, various documents not reviewed or read by others, as well as that records were incomplete or inaccurate. For example, the impression was given of Patricia being in a chair for 13 continuous hours and in bed for 17 hours with concerns about her fluid/nutritional intake as well as her personal needs. 5. Despite Patricia having fallen sometime in the early part of November no attempts were made at that time to take statements from various witnesses about the fall while events were fresh in their memories. Instead that had to be done as part of the Inquest process. That said, if there was a reluctance to be frank and candid then it was unlikely to manifest itself at the Inquest. It was deeply disappointing that vital information was not to hand about a resident having fallen or being found or assisted after a fall, especially when Patricia had a known history of falls. 6. The delay in getting treatment for Patricia in a more timely way did not cause or contribute to her death, but Patricia was probably in a lot pain for longer than she needed to have been. 7. There were numerous forms for staff to complete and read, instead of an integrated IT system. Staff were unsure, who had to complete the forms either for themselves,

	or on behalf others. 8. Comprehensive induction and on-going dementia training of staff may be beneficial to better appreciate the needs of those who suffer with dementia and the communication difficulties they have. 9. If there had been a suspicion of an unwitnessed fall, there ought to have been a realisation that an x-ray at the hospital was the only definitive and safe pathway to appropriate treatment, as opposed to examination by a nurse or GP. I have intentionally addressed this Report to the Secretary of State for Health and Social Care as I believe there may be lessons to be learnt nationally.
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 8th June 2018. 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: - • Family • Care Quality Commission (CQC) 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	Dated this 12th day of April 2018 Signature _____ Senior Coroner for the City of Sunderland