Regulation 28: Prevention of Future Deaths report

John Francis GREGORY (died 07.10.19)

	THIS REPORT IS BEING SENT TO: **1. Mr Jim Easton** **Chief Executive Officer, Health Care** **Care UK Community Partnerships Ltd** **Connaught House** **850 The Crescent** **Colchester Business Park** **Colchester** **Essex CO4 9QB** **2. [redacted]** **Corporate Medical Director** **University College London Hospitals NHS Trust (UCLH)** **University College Hospital** **2nd Floor Central** **250 Euston Road** **London NW1 2PG**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 21 October 2019, I commenced an investigation into the death of John Francis Gregory, aged 93 years. The investigation concluded at the end of the inquest on 17 March 2020. I made a narrative determination at inquest, which I attach.

4	**CIRCUMSTANCES OF THE DEATH** Mr Gregory was taken into hospital for a short stay and then from there to St Pancras Hospital Rehabilitation Unit Evergreen Ward, a satellite of UCLH. After seven weeks he was discharged to Muriel Street Resource Centre, a residential and nursing home run by Care UK, where he stayed for three weeks until he was brought back in to hospital. His medical cause of death was: 1a acute kidney injury 1b hypovolaemia due to low oral fluid intake 1c Alzheimer's disease and old age 2 hypertension
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. Mr Gregory died because he had not been drinking enough, though his Alzheimer's was not end stage, and before he was admitted to hospital he had been mobile; able to wash, dress and feed himself; and enjoy a good quality of life. **St Pancras Rehabilitation Unit Evergreen Ward** 1. Whilst the sister in charge of Evergreen plainly led from the front and expected the highest standards, these were not always maintained by every member of staff. On one occasion, a member of staff refused Mr Gregory's family assistance to take him to the toilet; on more than one occasion his family found him in wet bedclothes; and he was put to bed at 7.30pm to fit in with nursing routine. 2. His oral fluid intake was considered by Evergreen Ward, and steps were taken to address this, but the intake recorded on his charts demonstrate that it remained too low. Maintaining sufficient fluid intake was a challenge, but there is the possibility that not every member of staff encouraged him to drink and eat in the way the sister in charge did.

	Muriel Street Resource Centre 3. On the day he was readmitted to hospital from Muriel Street, Mr Gregory's family found him slumped unconscious in a public area of the home, a fact unnoticed by any member of staff. He was not properly strapped in to a wheelchair, slipping down because his feet were not on the foot rests. He was cold and inadequately dressed, with his shirt undone and not wearing socks. By then Mr Gregory was not capable of dressing himself. 4. Mr Gregory's oral fluid intake was also too low at Muriel Street, a nursing home specialising in the care of those with dementia. On his last day at the home, Mr Gregory was described in the nursing notes as drinking, but his chart showed that he had drunk nothing since a cup of tea at 8.20am. The ambulance was called at 5.17pm. The fact that he had not drunk the whole day was not escalated to a senior member of staff and there was no evidence that any steps had been taken to deal with this. His fluid intake chart recorded him as repeatedly declining drinks, even at a time after he had lost consciousness and an ambulance had already been called for him. This demonstrates that the chart was inaccurate. It raises the possibility that the chart was inaccurate in other ways. It raises the possibility that when Mr Gregory was described as declining drinks, in fact staff were not taking any steps to encourage him to drink, or to eat.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 18 May 2020. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted] inspection manager, adult social care, Camden, Islington & Enfield • [redacted] granddaughter of John Gregory. 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 20.03.20 *ME Hassell*