Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Director of Adult Social Services
Norfolk County Council
Martineau Lane
Norwich
NR1 2DH

Chief Executive
Norfolk and Norwich University Hospital
Colney Lane
Norwich
NR4 7UY

CORONER

I am YVONNE BLAKE Area Coroner for the coroner area of NORFOLK

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.

INVESTIGATION and INQUEST

On 8 October 2020I commenced an investigation into the death of Michael Yemm aged 77years. The investigation concluded at the end of the inquest on 2 February 2021. The conclusion of the inquest was Cause of Death 1a) Advanced Dementia and at 2 Fractured Neck of Femur, Ischaemic Heart Disease.
Conclusion- Natural Causes contributed to by several falls and fractured neck of femur.

CIRCUMSTANCES OF THE DEATH

Mr Yemm had a complex medical history including diabetes, hypertension, LVF, hypothyroidism and thyrotoxicosis. He had developed vascular dementia in 2017. He was cared for at home by family until his care needs increased. He was admitted to hospital and discharged to a residential home, despite protests from his family that a nursing home was safer and more appropriate. He had several falls whilst there and was admitted to hospital again. Every time he was admitted and discharged, he had to isolate (covid) upon his return he the care home, exacerbating his distress. After his second admission the manager of the care home told the hospital that they would not accept him back as his needs could not be met by them. Despite this without notifying the care home, Mr Yemm was dropped off by hospital transport and the home had no option but to keep him as he was left there. They did manage to obtain extra help, but his care needs increased, and he was again admitted to hospital. He had an in-patient fall after climbing over raised bed rails in a bay with staff present and fractured his left hip which required and hemiarthroplasty. The operation was successful, but Mr Yemm deteriorated and died in hospital with his family at his bedside (not being informed as the consultant report stated)

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:

That Mr Yemm was placed into a totally unsuitable and unsafe residential setting. Shortly after his arrival, the next day, the manager contacted Mr Yemm's social worker and told them they couldn't look after him properly. Despite this he was left in this care home. [redacted] wrote to the Director of Adult Social Services asking for help in finding a suitable placement and **did not receive the courtesy of a reply**. She was also told that after his falls that he had hairline fractures of his left hip before the fall in hospital.

The hospital dropped Mr Yemm off back at the care home without any warning after being informed that they could not have him back. He was also discharged on insulin which the home could not administer as they do not have trained nursing staff.

That he was able, in a cohorted patient bay, to climb past raised bedrails, he did not have a lowered bed, whilst staff were present. A cohorted bay has extra staff to deal with challenging patients and fell fracturing his hip, necessitating surgery. For the whole of his stay Mr Yemm was agitated, confused anxious and distressed, he had to move wards because of the need for surgery which further exacerbated his condition.

[BRIEF SUMMARY OF MATTERS OF CONCERN]
(1) The care home placement
(2) The hospital discharge despite being told they couldn't send him back, and just leaving him there.
(3) The in-patient fall and care of dementia patients.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 30 March 2021. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

[redacted]

I have also sent it to:

Department of Health
Care Quality Commission
HSIB
Health Watch Norfolk

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. Dated: 02 February 2021

Yvonne BLAKE
Area Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich NR1 2T