**Worcestershire Coroner**

**D.D.W. REID**

**SENIOR CORONER**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>1) [redacted] Managing Director, Holmleigh Care Homes Ltd., Unit 1, Mill Place, 90 Bristol Road, Gloucester, GL1 5SQ;<br>2) [redacted] Plexus Law, 30-36 Monument Street, London EC3R 8NB;<br>3) [redacted] Field Fisher Solicitors, 2 Swan Lane, London EC4R 3TT;<br>4) [redacted] Care Quality Commission, Citygate, Gallowgate, Newcastle-upon-Tyne NE1 4PA;<br>5) The Chief Coroner of England and Wales. |
| 1 | **CORONER**<br><br>I am David Donald William Reid, HM Senior Coroner for Worcestershire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 24/12/2018 I commenced an investigation into the death of Rachel Bernadette Johnston, a resident at Pirton Grange Nursing Home, Pirton, Worcs. ( Pirton Grange ). Holmleigh Care Homes Ltd. owns Pirton Grange. The investigation concluded at the end of the inquest 26th March 2021. The conclusion of the inquest was as follows:<br>"On 26.10.18 Rachel Johnston, who had significant physical and learning disabilities, underwent necessary and extensive dental surgery under general anaesthetic. Having been discharged that evening back to Pirton Grange Nursing Home, Pirton, where she lived, she developed aspiration pneumonia which resulted in her being admitted as an emergency to Worcestershire Royal Hospital on 28.10.18, where she was found to have suffered an unsurvivable hypoxic brain injury. She was discharged back to Pirton Grange Nursing Home for end of life care, and died there on 13.11.18. Nursing staff at Pirton Grange Nursing Home failed to carry out adequate physiological observations on Rachel after her discharge following the dental surgery and failed to seek emergency medical assistance for Rachel from the evening of 27.10.18 when her condition clearly required it. Had emergency assistance been sought for Rachel at that time, she would probably have survived, and not have died when she did."<br>Rachel's medical cause of death was:<br>1a cerebral hypoxia<br>1b aspiration pneumonia<br>1c dental extractions<br>2 hydrocephalus and epilepsy following childhood meningitis. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>see above. |
| 5 | **CORONER'S CONCERNS**<br><br>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 Civic Martins Way Stourport on Severn DY13 8UN**

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| | The **MATTERS OF CONCERN** are as follows:–<br><br>(1) Following Rachel's death, there appears to have been no adequate internal investigation or disciplinary procedure which was able to identify the gross failings of the nurses mentioned above. Accordingly, both nurses continued working at Pirton Grange for some time, without any action being taken to ensure that patients were not put at risk by their actions. Furthermore, no effort was made to report the conduct of the nurses concerned to the Nursing and Midwifery Council ( NMC ), the appropriate regulatory body, until February 2021, over 2 years after Rachel's death;<br><br>(2) Even now, there appears to be no Policy in place at Pirton Grange which sets out a suitable and robust procedure for:<br>(a) identifying and investigating possible misconduct by nursing staff, e.g. where they have ignored a Policy;<br>(b) imposing an interim suspension on a member of the nursing staff, pending the completion of such an investigation, if in the interests of ensuring the ongoing safety of residents;<br>(c) if appropriate after the investigation has been completed, ensuring that member of the nursing staff does not work at Pirton Grange again; and<br>(d) if the internal investigation has identified likely misconduct, reporting that member of the nursing staff to the NMC. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely **by 21st May 2020**. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>1) [redacted], Plexus Law, the solicitors representing Pirton Grange at the inquest;<br>2) [redacted], Field Fisher Solicitors, the solicitors representing Rachel's family at the inquest;<br>3) [redacted], Care Quality Commission.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | 26/03/2021<br><br>Signature [signature]<br><br>David Donald William Reid<br>**HM Senior Coroner for Worcestershire** |