IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Dilys Greta Etchells
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: [redacted] **– Regional Care Home Manager for Aden Nursing Home**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 16/7/21, I opened an inquest into the death of **Dilys Greta Etchells** who, at the date of her death was aged 90 years old. The inquest was resumed and concluded on 29/10/21 I found that the cause of death to be: - 1a Aspiration pneumonia 1b Advanced Alzheimer's Dementia II Traumatic fractures of left tibia and fibula I concluded with a narrative conclusion as follows: On 3/6/21 Dilys Greta Etchells, who suffered with Alzheimer's was found on the floor of her room at Aden Court Nursing home by her nursing staff after an unwitnessed fall from her bed. After examination, she was placed back in the bed. Thereafter, on 6/6/21 nursing staff reported her left leg to be swollen and discoloured and she was taken to hospital where she was found to have suffered a fractured tibia and fibula, and her leg was placed in a cast before she was discharged back to the care home. Subsequently, she attended an outpatient's appointment at the fracture clinic on 24/6/21 in order to review the cast on her left leg, when an examination confirmed that she had developed an ulcer behind the knee to the cast. As a result, she was admitted to hospital, but despite treatment she succumbed and died on 2/7/21. It is found more likely than not that she received suboptimal care whilst she was a resident at Aden Court Nursing

	Home, given that at the time of her fall precautionary measures were not in place to prevent it and basic checks were not carried out to monitor her state of health thereafter.
4	**CIRCUMSTANCES OF THE DEATH** Upon 3/6/21 Dilys was found on the floor in her room at her nursing home at Aden Court at approximately 3am by nursing staff. At the time she was examined, no injuries were reported and she was placed back into her bed. Subsequently on 6/6/21 her GP was called out after her care staff found her left leg to be swollen and discoloured. This resulted in her admission to Huddersfield Royal Infirmary due to a suspected leg fracture. At the hospital it was confirmed she had sustained a fractured tibia and fibula and her leg was placed in a cast before she was discharged back to her care home. Thereafter on 24/6/21, Dilys attended an outpatient's appointment at the fracture clinic at HRI in order to review the cast on her leg and it was then that the tissue viability nurse found her to have developed pressure ulcers to 4 areas of her left leg and ongoing sores to her right foot, such that she was admitted to ward 19, but notwithstanding treatment she succumbed and passed away on 2/7/21. At the inquest it was accepted by the care home that Dilys had received sub optimal care given that there was no evidence to suggest that crash and sensor mats were positioned under her bed at the time of the fall and no evidence to confirm how long she had been lying on a hard floor between 2am and 3am. Thereafter, when she was discovered, it was accepted that she should have been immediately referred to a hospital doctor, and there was found to be no supportive documentation to cover her treatment and care leading up to and after admission, particularly with respect to the pressure sores and any advice given by the hospital.
5	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is as follows: - • To review and reconsider the adequacy of the provision of crash and sensor mats and the means for properly documenting their use and reporting accidents when they take place.

	• To review existing practices with regard to the adequacy of note taking and to consider protocols to ensure compliance with care plans. • To give consideration to staff training with respect to visual checks at handover to ensure resident's needs are met in accord with the care plans. • Consider the adequacy of the supporting documentation with regard to visual checks on residents in their rooms. • To consider the necessity of staff training with regard to communications at handover and dealing with correspondence received from the hospital with regard to patient care. • To review existing protocols governing wound management, completion of admission documentation, care plans, initial wound assessment, body maps, consent to medical treatment form and the return from hospital form.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Aden Nursing Home, has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to: • [redacted] - Daughter • CQC • Chief Coroner
9	**DATED this 23/12/21** MD Keey