Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Hamilton Community Homes Limited
1	**CORONER** I am Miss F BUTLER, Her Majesty's Assistant Coroner for the coroner area of Leicester City and South Leicestershire
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 10 March 2021 I commenced an investigation into the death of Jane Louise SHILTON aged 56. The investigation concluded at the end of the inquest on 16 February 2022. The conclusion of the inquest was that Jane's death was an alcohol related death.
4	**CIRCUMSTANCES OF THE DEATH** Jane had a long history with mental health and specifically psychiatric services since her teenage years. She was diagnosed with paranoid schizophrenia in 1989, when she was just 25 years of age. The nature of Jane's illness was one of a severe and enduring type and due to the chronicity and severity of Jane's illness, as the years progressed, she needed more support. Jane was managed by the Care Programme Approach model and was subject to a Community Treatment Order with the main condition being to ensure she was compliant with her depot injection of Zucolplenthixol. However, Jane required a lot of support and her accommodation needs increased from supported accommodation to full time residential care in June 2019 (following a lengthy period of in-patient acute admission). Jane was discharged to Hamilton House, a residential care home providing 24-hr care to those with mental health needs. Despite an initial positive impact between November 2019 and April 2020, there was a gradual decline in Jane's mental health, some of this related to CV19 lockdown. Input from her Community Psychiatric Nurse in the Assertive Outreach Team was increased. Jane was at this stage under an appointeeship with Leicester City Council. This meant that Hamilton House managed Jane's finances in an aim to safeguard and support Jane both with her consumption of alcohol and cigarettes but also Jane's vulnerability. A review of Jane's care package was carried out and it was decided by Leicester City Council that they would fund 5 additional hours of 1:1 support per day for Jane during the lockdown period so that the staff at Hamilton House could offer support and proactively spend time with Jane. This additional funding remained in place at the time of her death.

Jane was not an alcoholic. She was a social drinker, but lacked insight into her underlying difficulties and part of the rationale for the move to a 24 hour residential care setting was to negate the risk to Jane who was identified as being at "high risk of exploitation", and had "limited awareness of risks to her health and wellbeing and was unable to recognise her own vulnerability and/or when she may be subject to exploitation from others". These risks were exacerbated to an even greater extent when Jane drank alcohol, as it increased her disinhibition.

Hamilton House had a policy of no drinking on the premises.

Jane had been drinking alcohol on the night of the 08.03.2021 (circa 24 hours before her death). I heard evidence that her intoxicated state (slurred speech and stumbling) was unusual. Jane retired to bed on the night of the 08.03.21 and nothing further was done by Hamilton House in respect of this incident. It was noted that Jane had also started to drink spirits (Vodka) which again was unusual. I heard evidence from support workers at the home who were unaware of any particular vulnerabilities or risks for Jane when drinking alcohol with her medication, despite there being a care support plan in place for Jane which clearly outlined this.

Jane was not checked upon during that night and it was not policy or custom for night staff to proactively check on residents during the night. Whilst Hamilton House is described as offering 24 hours residential care, there are no waking staff on shift during the night and staff go to sleep between the hours of 11pm and 8am but are on call if required by residents.

Jane made breakfast the following morning (09 March) and was seen by support workers within the home by 8am, for cigarettes, juice during breakfast and then took herself to the shops shortly after 9am.

I heard in evidence from the care home manager that she had seen Jane further throughout the day, of the 09 March and she had been fine in the day. Whilst the care home manager had been aware that Jane had been intoxicated the night before she had not sought to address this with Jane that day contrary to Jane's support plan. Jane was last seen by staff at the home at around 3pm on 09 March.

Staff came on for the evening shift at 5pm. There was nothing of concern handed over about Jane.

Jane did not present for her medication at just after 5pm. I was concerned to learn that the care home staff who gave evidence before me didn't have an appreciation as to Jane's medication and whether the missed medication would cause risk to Jane. Consequently, when Jane didn't attend there was no check on her welfare.

Jane didn't make dinner that evening. I was told in evidence that Jane's attendance at dinner could be variable and she often attended late for dinner (around 6pm) and that staff would save her a meal. However, no one checked on Jane's welfare when she did not show for dinner.

Jane didn't attend for a cigarette during the evening. I was told in evidence that Jane was a regular smoker and it was normal for Jane to be seen by staff frequently going outside for a cigarette. Jane was not seen doing this during the course of the evening of 09 March. No one went to check on her.

At 10.10pm a support worker became concerned and went to check on Jane but also another resident, who also hadn't been seen. She found them both in Jane's bedroom. Jane was under a duvet and unable to be seen. The other resident acknowledged the light being turned on by the support worker and in response to her request to leave (it being against home policy for residents to sleep in the same room) asked for the light to be

	turned off. The support worker didn't turn the light off but left the room with the intention of going back later to check the other resident had left. There was no physical check of Jane at 10.10pm. She could not be seen under the duvet and was unresponsive to the presence of the support worker. At 11pm both support workers present on the evening shift within the home went to bed. As one was getting into bed the resident knocked on her door and said he thought Jane was dead. What followed is concerning in the context of trained care professionals who are entrusted with the responsibility of looking after vulnerable individuals when faced with a medical emergency. • On attending Jane's room Jane was described as being on the bed. Her body was in a strange position with her head and back against the side of the bed and her legs in a contorted position. • Neither support worker checked for a pulse or whether Jane was breathing but made an assessment given Jane's demeanour that she was dead. • Both members of staff left the room together to contact emergency services – leaving Jane unattended. • No one placed Jane the recovery position or attempted to commence CPR • On contacting 999 services a landline phone was used and when emergency services requested the caller to be at the side of Jane to carry out vital basic checks (breathing for example) the support worker had to use own mobile phone to facilitate her being able to talk to emergency services whilst with Jane • The description given as to the attempts to move Jane in order to deliver CPR again is concerning – with Jane falling off the bed and then becoming inaccessible between the bed and the wall. CPR was not delivered. Whilst none of this made a difference to Jane who had sadly passed away, it could make all the difference to another resident's survival. The Ambulance attended and Jane was sadly pronounced dead at the scene.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) I was told during the inquest that Hamilton House First Aid Training was uptodate at the point Jane died and I have since been provided with the First Aid Training Certificates which evidence that First Aid Training was provided to staff once every 3 years, and this was in 2018 and staff had received update training in 2021, within the 3 year time frame. I remain concerned and that concern is heightened when having heard the evidence of the support workers on shift that evening to learn that updated first aid training was only undertaken 5 days prior to this incident. I understand that the first aid training in 2021 was delivered online given the Cv19 restrictions. I further understand that whilst yearly first aid refresher training can be undertaken Hamilton House have not required staff to undergo such training. As I have found in this inquest sadly for Jane the failure to attempt to deliver any first aid

	would not have made any difference in her case as she had been sadly passed away for some time. However, the way in which the incident was handled which is evident from the 999 call which gave rise to a safeguarding alert does deeply trouble me especially in the context of learning that refresher training had been received by the individuals engaged with the incident only 5 days prior. This causes me to question quality of that training in the context of an online setting given the pandemic. I am further concerned that first aid training is only undertaken at the minimum requirement of every 3 years, given that Hamilton House is charged with the responsibility of looking after some of society's most vulnerable individuals who I am told have co-existing difficulties of both mental health but also substance misuse.
6	**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.
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 April 2022. 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 The Family Leicester City Council Leicestershire Partnership NHS Trust Care Quality Commission who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 22/02/2022**  **Miss F BUTLER** **Her Majesty's Assistant Coroner for** **Leicester City and South Leicestershire**