ANDREW HETHERINGTON
HM Senior Coroner for North Northumberland and
Acting Senior Coroner for South Northumberland

County Hall Morpeth Northumberland NE61 2EF

[redacted]

Date: 16 June 2021 [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Baedling Manor Care Home, Alcyone Healthcare.

CORONER

1 I am Mr Andrew Hetherington for Northumberland

CORONER'S LEGAL POWERS

2 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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 7 January 2021 I commenced an investigation into the death of William Stanton RUTHERFORD. The investigation concluded at the end of the inquest.

Dr Whitehouse found the cause of death to be:

1a Pneumonia

1b Fractured Ribs

1c

II Frailty of Old Age

I concluded the inquest at County Hall, Morpeth on 4 June 2021 as follows:

3

Box 3.

The deceased was a temporary resident within Baedling Manor Care Home, Bedlington from 14 November 2020 and was for one to one care. He had suffered a fall on 5 December 2020 and had been seen by a doctor on 10 December 2020. He was prescribed antibiotics on 24 December 2020. On 28 December 2020 he was taken to Northumbria Specialist Emergency Care Hospital following a further fall and was found to have sustained fractures to his left and right ribs. He had pneumonia but despite treatment he deteriorated and died within Northumbria Specialist Emergency Care Hospital on 5 January 2021. The precise circumstances of where and when the rib fractures were sustained remains unascertained.

Box 4

Died as a consequence of injuries sustained in a fall the precise circumstances of which remain unascertained and it is not possible to identify the specific incident that led to death.

CIRCUMSTANCES OF THE DEATH

Mr Rutherford was a temporary resident at Baedling Manor Care Home from 14 November 2020. He was initially for respite care and the plan was he would be transferred to a care home were his wife was a also resident. Sadly she died in December 2020. Alternative accommodation was being sought. Mr Rutherford suffered with dementia and he was for one to one care whilst at Baedling Manor Care Home. This level of care included visual observations 24 hours a day. He was described as independent mobility wise and for his own needs. On 5 December 2020 Mr Rutherford was found on the floor of his room. He had redness to his forehead and complained of being sore to the hip. He was seen by the GP on 10 December 2020 and was able to walk normally. On 24 December 2020 the GP prescribed antibiotics. On 28 December 2020 I heard evidence from staff that were assisting Mr Rutherford with his needs and helped him change his bed clothes. Very shortly after, whilst staff told me they were still in his room, he was found on the floor. It was not clear on the evidence how he came to be on the floor and when staff checked Mr Rutherford he was found to have bruising to his left side and a red mark to the right. No member of staff had noticed the bruising before. I found the circumstances of the incident as described to me by the witnesses to be confused and disjointed.

A call was made to 111 and paramedics attended. Mr Rutherford was taken to Northumbria Specialist Emergency Care Hospital and was found to have sustained several rib fractures. A CT scan reported 'acute left 5th to 12th rib fractures seen. Left 11th rib is fractured at 2 areas. Right 11th rib is also fractured. There are also old rib fracture bilaterally' (L 5th - 12th rib #s)'. He was given antibiotics but he continued to become more unwell and it was felt he would not survive the admission. The decision was made to move to comfort-based care, and he was put onto the care of the dying patient document. Mr Rutherford died within Northumbria Specialist Emergency Care Hospital on 5 January 2021.

I heard that the minimum staff requirement overnight would six members of staff but that provides for sickness and it would be the expectation there would be five members of staff on duty overnight. I heard than on 28 December 2020 there were 42 residents at Baedling Manor but that Mr Rutherford was the only resident at that time receiving one to one care. I heard that on 27 December 2020 there were four members of staff on duty. Witnesses were unable to tell me how many staff were on duty on the evening of 28 December 2020 but could not confirm that there were more than four members of staff on duty.

I have previously expressed concern as to the standard of record keeping at Baedling Manor and that the record keeping did not represent an accurate picture. It was reaffirmed to me in evidence today that record keeping in the case of Mr Rutherford was not up to standard either and was still a work in progress. I have received no response to my earlier Regulation 28 report, with the response falling due on 14 April 2021

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. –

5 (1) I am concerned that staffing levels were below the minimum requirement on 27 and 28 December 2020. Mr Rutherford was for one to one care and I am concerned that the appropriate number of staff were not available.

(2) I have previously raised concerns regarding the standard of record keeping at Baedling Manor Care Home. I have not received a response to my previous concerns which I repeat again. This is the second death where a resident has died following a fall at Baedling Manor Care Home and I am concerned that the record keeping does not reflect the needs of the residents or accurately record incidents as they occur.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you 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 7 30 July 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 the family of Mr Rutherford and to the Care Quality Commission, and Safe Guarding.

I am also under a duty to send the Chief Coroner a copy of your response.
8

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.

4 June 2021

9 Signature 

Andrew Hetherington HM Senior Coroner for North Northumberland and Acting Senior Coroner for South Northumberland.