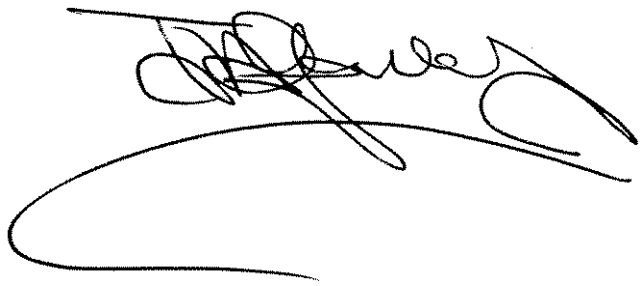
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Registered Manager (RM) Litch Care For action** **And the following for information/action as appropriate.** **Next of kin -** [redacted]**, second cousin.** **Care Quality Commission** [redacted] **HM Chief Coroner HHJ T. Teague QC**
1	**CORONER** **Julie Goulding** **HM Senior Coroner** **Sefton St Helens & Knowsley**
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 29/06/2020 I concluded an investigation and Inquest touching upon the death of Joan RICHARDSON 07/08/1921- 18/05/2020. Joan died in Whiston Hospital Merseyside. The conclusion of the inquest was that: Joan Richardson sadly died on 18/05/2020 at Whiston Hospital Merseyside. Joan was a frail 98-year-old lady who had lived alone in supported accommodation. In April 2020 Joan's condition started to deteriorate, she was requiring more support with personal care, she was not eating enough for her needs and she was also showing signs of confusion. Joan had a DNAR in place and she was taken to hospital on 04/05/2020 due to concerns from her carers that she was becoming less responsive/her condition was deteriorating. On admission to hospital Joan was diagnosed with pneumonia, she had deep tissue wounds (grade 4) to her sacrum that were not infected, and she was also found to have a fractured neck of femur. On 07/05/2020 when Joan was clinically as stable as possible, she underwent surgery to her hip. Following surgery notwithstanding all appropriate care and treatment in hospital Joan's condition continued to deteriorate culminating in her death. In summary/conclusion, on 23/04/2020 the warden from the accommodation complex called an ambulance such was her concern about Joan's deterioration, however, the ambulance service determined Joan did not need to go to hospital but she did need help with personal care. The warden had shown great compassion towards Joan. On 24/04/2020 Joan was assessed as needing home care by the local authority (Adult Social Care) in a timely manner and care was provided until a care provider was able to

	take over her care on 29/04/2020, 4 times per day. Joan was not seen up out of her bed after the bedtime visit on 30/04/2020 when she was noted by carer's to have been in the kitchen. After that Joan remained in bed and she presented as being unwell and she showed signs of being in pain when the provision of personal care was attempted which she generally refused. Carers were unable to change her regularly or to provide pressure area care or relief as was necessary for Joan who was frail, elderly, immobile and incontinent. Following her admission to hospital Joan received all appropriate care and treatment, however when at home, following the appointment of care providers some care related documentation/care plan was not completed in a timely manner by the care provider in the four days that Joan was under their care as it should have been and the deterioration in Joan's poor condition, the fact that she no longer got up from her bed, refusal to eat and have assistance with her care needs and stated that she did not feel well should have been escalated as being of significant concern and to have enabled additional/appropriate action to be taken but it was not and Joan did not receive care to her pressure areas, noting she was admitted to hospital with a grade 4 pressure ulcer to her sacrum. A carer did seek advice from a senior member of staff who visited Joan and subsequently an ambulance was called during the early morning visit 04/05/2020 when Joan was admitted to hospital.
4	**CIRCUMSTANCES OF THE DEATH** Joan RICHARDSON had lived independently in sheltered housing. Her health began to deteriorate in April 2022 and on 29th April 2020 Joan began to receive home care four times per day by a care provider known as Litch care. The sole Proprietor being [redacted] also known as [redacted]. Joan was admitted to hospital on 4th May 2020.
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 Medical Cause of death was given as 1a. Bronchopneumonia II Neck of femur Fracture (operated 07/05/20), frailty. Joan had lived independently, she had been mobile within her apartment until the evening visit on 30/04/2020 when she was in the kitchen, after that she was never seen out of bed again, she was refusing personal care and eating/drinking very little if anything, her condition was deteriorating, and she was telling care staff that she was in pain. Her food and drinks were being left (largely)untouched. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) Joan had only started to receive care at home four times per day from lunch time of 29/04/2020, however when Joan failed to get up from her bed, refused food and fluids, complained of pain and generally started to deteriorate;- 1. The matter of Joan's general deterioration was not escalated as it should have been to her GP/District Nurse/Commissioning Social Services etc. 2. When Joan complained of pain -the matter was not escalated as it should have been. 3. There was no comprehensive plan of care, risk assessment, pressure area care

	plan/risk assessment, falls assessment and care plan put in place following assessment by Litch care services. The manager/proprietor [redacted] Registered manager informed the court they were still in the process of doing risk assessment/s etc because Joan was only receiving their care for 4.5 days before she was admitted to hospital. 4. Joan was admitted to hospital with Grade 4 pressure ulcers/tissue injuries to her sacrum, but because Joan had refused much of the personal care offered to her and she had remained largely immobile in bed the pressure sores/tissue injuries were not documented, assessed or managed as they should have been nor was the tissue viability nurse, GP, District nurse or social care team informed to enable them to commence/prescribe appropriate treatment. 5. There were no records/daily log making any mention of skin integrity/breakdown even though Joan was in bed, frail, immobile and incontinent in addition to which because Joan was refusing care her incontinence pads were not being changed regularly. 6. Training/education, support & supervision of care staff including the provision of clear escalation procedures was inadequate. Noting care staff attended upon Joan regularly as required.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. An action plan must now be developed and produced, the plan must show what action is required, how this will happen and how it will be audited and monitored.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, by 19th August 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 [redacted], second cousin, Care Quality Commission, and [redacted] ([redacted]), 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: 01/07/2022**



Julie GOULDING
Senior Coroner for
Sefton, St. Helens and Knowsley