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:** **The Manager** **Broadland View Care Home** **147 Yarmouth Road** **Norwich** **Norfolk** **NR7 0SA**
1	**CORONER** I am Jacqueline LAKE, Senior Coroner for the coroner area of Norfolk
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 26 June 2020 I commenced an investigation into the death of Eileen Marguerite WALSH aged 97. The investigation concluded at the end of the inquest on 27 July 2023. **The medical cause of death was:** 1a) Frailty, Old Age 1b) 1c) 2) Osteoporotic Neck Of Femur Fracture (operated on 02/03/2020), Dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Chronic Kidney Disease, Ischaemic Heart Disease **The conclusion of the inquest was:** Mrs Walsh died following an unwitnessed fall in Broadland View Care Home. Required hourly checks were not completed during the night prior to her fall. Her bed was not in the lowered position as required. The PIR sensor and pressure mat alarms did not sound. Mrs Walsh's death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Walsh had a significant medical history including dementia and general frailty. Mrs Walsh was admitted to Broadland View Care Home on 3 March 2019. Following falls on 5 November 2019 and 12 February 2020 Mrs Walsh's Care Plan was updated to include steps to mitigate risks by 1. Leaving on hall light, 2. Providing a PIR sensor alarm, 3. Pressure mat alarm, 4. Hourly checks. Mrs Walsh was also provided with a bed which was to be lowered at night to prevent her being able to stand up to get out of bed. The records show that Mrs Walsh was checked and found to be in bed and asleep at 20.31, 21.41, 22.33, 23.35, 00.33, 01.23, 02.33, 03.35, 04.34 and 05.36 on the night of 29 February/1 March 2020. At about 6.15 am Mrs Walsh was heard to call for help and was found on the floor in her

	room, some 4 or 5 steps away from her bed. Emergency services were called and Mrs Walsh was taken to Norfolk and Norwich University Hospital where she underwent an operation to fix a fractured right neck of femur. Mrs Walsh's condition continued to deteriorate and she died on 3 March 2020. Evidence was heard that Mrs Walsh was not checked at 21.41 and 23.35 on 29 February 2020, nor at 01.23 or 03.35 or 05.36 on 1 March 2020 as recorded in the records. Evidence was heard that Management were aware that a carer regularly slept whilst on night duty. Mrs Walsh's bed was not lowered. The PIR sensor and the pressure mat alarms did not sound. The evidence does not reveal whether this was because the alarms had not been set or whether the equipment was faulty. The evidence does not reveal the exact time at which Mrs Walsh fell or for how long she was lying before she was found.
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: 1. A Night Working Policy was being prepared but this is still not completed some 3 years following Mrs Walsh's death. 2. Evidence was heard that a new electronic system to monitor checks on residents was being sourced. This is not in place some 3 years following Mrs Walsh's death. 3. Evidence was heard that carers are responsible for work alongside caring for residents, including cleaning and laundry, A Night Tasks List was referred to as being "currently under review" and under the heading "Actions" was included "Implement revised night staff task list" in an investigation carried out by Adult Safeguarding in an Adult Safeguarding Record from 2022. As at the date of the inquest this document was not complete. There was no evidence as to what this List would include. 4. An investigation carried out by the Home found that records had been edited and some falsified by a member of staff. A statement made by the new Deputy Manager at the Home dated 14 July 2023 stated that only senior management could go into the system to edit existing records. Evidence was heard at the inquest from the Registered Manager who stated that care staff can access and edit the records. It is a concern that senior management are unaware the system can be edited as well as a concern that it is acceptable for staff to edit entries. 5. Conflicting evidence was heard as to whether night staff are allowed to sleep during breaks whilst on night shift. 6. The warning alarms requiring immediate response cannot be heard in all places at the Care Home. It is understood walkie-talkies have been introduced for use by all staff but this adds in another step to be taken by staff before the alarm is responded to. 7. The Director of Training and Operations referred to the Incident Investigation carried out internally and found that PIR sensors were not in use in Mrs Walsh's room at the time of her fall. PIR sensors were referred to in witness evidence and also in Mrs Walsh's Daily Care Notes. It was found at the inquest a PIR sensor was in Mrs Walsh's room at the time of her fall and the PIR sensor did not sound an alarm as required in the Care Plan, at the time of Mrs Walsh's fall. It is a concern this investigation did not read Mrs Walsh's Care Notes before reaching this conclusion when concerns that the PIR sensor did not sound could have been addressed. 8. The Care Quality Commission carried out an inspection in February 2023, nearly 3 years following Mrs Walsh's death, and raised similar concerns as raised during this inquest, including: a) Safeguarding concerns had not always been appropriately identified and referred

	b) Risks relating to falls were not dealt with, including a faulty sensor mat was still in place some days later c) Since a historic issue of staff neglect, further incidents of poor staff performance were identified and effective action had not always been taken. It is stated this failure to learn lessons placed people at risk of harm d) Recent audits carried out by the Home had not identified concerns found by the CQC 9. The Registered Manager did not accept many of the concerns raised by the CQC during their attendance and this is a missed opportunity to learn lessons, improve care and prevent future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 September 25, 2023. 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 I have also sent it to: • Family of Mrs Walsh • Care Quality Commission • Healthwatch Norfolk • Adult Safeguarding – Norfolk County Council • Adult Safeguarding – Norfolk Constabulary 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: 31/07/2023** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH