Regulation 28: Prevention of Future Deaths report

Doris Irene URCH (died 28.02.23)

	THIS REPORT IS BEING SENT TO: **1.** **Managing Director** **Globe Court Care Home** **50 Globe Road** **London E1 4DS**
1	**CORONER** I am: Harry Lambert Assistant Coroner Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 3 March 2023 the Senior Coroner, Mary Hassell, commenced an investigation into the death of Doris Urch aged 90 years. The investigation concluded at the end of the inquest on 27 July 2023. The Inquest found that on 6th February 2023 Ms Urch fell, after her carer omitted to offer her support whilst ambulating. The risk of falls had been inadequately addressed in the Risk Assessment documentation and procedure. Although the Deceased appeared not to be seriously injured in the wake of the accident it was later confirmed on CT scan that she had suffered a brain injury, from which she later died I returned a narrative conclusion in the following terms: *On 28th February 2023 Ms Urch died from an intracranial haemorrhage*

	sustained in a fall on 6th February 2023, after her carer omitted to offer support whilst ambulating. The medical cause of death was 1a Acute left frontal intracranial haemorrhage 2 Alzheimer's Dementia
4	**CIRCUMSTANCES OF THE DEATH** Doris Irene Urch, aged 90, suffered from Alzheimer's dementia, and age related macular degeneration, and was known to have a high risk of falls. I was told by [redacted], from whom I heard evidence, that the most risky transition was from standing to sitting and that during this transfer the Deceased, due to her visual impairment, would often miss the seat and fall. It was "part of her" which I took to mean an inherent and constant risk. [redacted], the care home manager, candidly accepted that "we all knew you had to watch Doris when she sits down". On 6th Mrs Urch was in the lounge of Globe House when she became distressed, lost her balance and fell. It is clear that Ms Urch was not being supervised or assisted by the only carer present, [redacted], who was "sitting…with the other residents". [redacted] acknowledged that this was a mistake. She was taken to Hospital where a CT scan evinced a large acute left frontal intracranial haemorrhage with extensive longstanding cerebral atrophy. It was decided that surgical intervention was not in her best interests and the focus shifted to palliative care. She passed away on 28th February 2023 at around 03:30 hours.
5	**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.

	(1) The Question and Answer tickbox form for Risk Assessment seemed to me to leave much to be desired. It was excessively binary and meant that those who filled it in did not need to "engage" with the particular patient. (2) The Risk Assessment did not make no recommendations or suggestions as to what to **<u>do</u>** about the risks identified. (3) Staff seemed unfamiliar with the risk assessment/care plan, which I consider more of a systemic problem. It is unclear if/when care plans were reviewed by staff. (4) The care plan/risk assessment was not updated in light of a fall in November/December 2022. I was concerned that potentially significant developments might not be being taken into account in keeping the care plan under review. (5) The system does not preserve old care plans in their contemporaneous format which is a serious shortcoming which has the potential to hinder future investigations. I encourage that system to be reviewed.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 6th October 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 following. • [redacted], aunt of Irene Urch • Care Quality Commission for England • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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 other 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.
9	**DATE** **SIGNED BY ASSISTANT CORONER** 11.08.2023