REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Frome Nursing Home** **Styles Hill** **Frome** **Somerset** BA11 5JR [redacted]
1	**CORONER** I am Mrs Samantha Marsh, Senior Coroner, for the coroner area of Somerset
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 the 20th of October 2022 I commenced an investigation into the death of Irene Joy White, aged 77. The investigation concluded at the end of the inquest on the 1st of November 2023. The conclusion of the inquest was '*The deceased died of a pulmonary embolous which developed on a background of early discontinuation of thromboprophylaxis and immobility following a fall and fixation operation*" with the medical cause of [redacted] death being given as: Ia) Saddle Pulmonary Embolous Ib) Deep Vein Thrombosis Ic) Immobility II) Fractured neck of femur (operated on in June 2022)
4	**CIRCUMSTANCES OF THE DEATH** Mrs White had a diagnosis of dementia and had lived in her previous care home since November 2019. Unfortunately her cognitive impairment meant that her behaviours put others at serious risk of harm and/or death (she is recorded as having tried to suffocate another resident with a pillow) and so her previous home had identified that they could no longer meet her needs and sought to find another appropriate placement for her due to being unable to manage her unpredictable aggression and 'assaults' on other vulnerable residents. On the 29th May 2022 she was found on the floor of her previous care home

	having suffered an unwitnessed fall. She was conveyed to hospital where it was revealed she had sustained a fractured hip. She underwent a surgical fixation operation on the same day. Post operatively she was given two forms of thromboprophylaxis: (i) Chemically, with inhixia injections; and (ii) Physically with TED compression stockings. Mrs White was discharged to a new Nursing Home, Frome Nursing Home, on the 17th June 2022 and was discharged with no thromboprophylaxis (either chemical or physical) and no advice. Mrs White was due to have a further nine days of thromboprophylaxis to complete the routine 28-day course (having only had 19 days at the point of discharge). Frome Nursing Home is an Older Persons Mental Health care home, so can accept residents with complex dementia needs, such as Mrs White. There is at least one qualified and registered Nurse on duty 24/7. Mrs White had no risk factors that pre-disposed her to developing a DVT; her risk factor was immobility following her fall. Irene was not provided with any thromboprophylaxis measures and was not mobilised over and above being repositioned every four-hours for skin integrity and pressure-sore prevention. Mrs White died of a pulmonary embolism, which developed following her fall and immobility, on the 20th of October 2022. .
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 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. – I am concerned following the evidence presented to the Inquest that: (i) Frome Nursing Home employs clinically trained staff who would have been well aware (or should have been well aware) of the risk of developing DVT in an immobile patient and yet: (a) Did not make any enquiries with the discharging hospital as to her care needs and lack of thromboprophylaxis. Despite appropriate medical/clinical knowledge the Home did not question this and/or take any active steps whatsoever to ascertain Mrs White's needs or treatment plan; (b) Did not take any steps to acquire any TED stockings, or similar, to minimise the risk of a DVT; (c) Did not take any steps to mobile Mrs White, over and above repositioning her in bed every four hours, to minimise the risk of a DVT (ii) Frome Nursing Home did not have a DVT Policy in place at the time of

	Mrs White's death, and no such active policy was in place at the time of the Inquest and so I am concerned that there has been no active learning and/or meaningful reflection since Mrs White's death; meaning that practices have not changed and vulnerable residents remain at risk. I am concerned that the Home did not take appropriate and reasonable steps to identify her risk and then take such steps to minimise it. The overwhelming thrust of the evidence presented indicated a poor attitude to a joined-up and cohesive response from the management and clinical teams and this resulted in a lack of clinical leadership, judgment and action being taken. Mrs White lacked capacity due to her cognitive impairment and so was unable to appreciate the risks that immobility posed to her. She was entirely reliant (because of age, cognitive impairment and general infirmity) on the Home to anticipate her risks and needs in this regard.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the **2nd January 2024.** I, the coroner, may extend the period and am conscious that the deadline falls on Boxing Day. I would appreciate an early request for an extension if a response cannot be provided before Christmas closures. 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: (i) the Chief Coroner (ii) Mrs White's family (iii) Care Quality Commission 2 Redman Place London E20 1JQ [redacted] 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	 **7th November 2023**