REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Regional Operations Manager, Choice Support, Ground Floor, 100 Westminster Bridge London. SE1 7XA.
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 12th and 13th December 2023 evidence was heard touching the death of Mr David Hemmings. He had died on the 4th June 2021, aged 73 years. **Medical Cause of Death** 1 a. Peritonitis b. Wound Infection c. Complex right hemipelvic fractures (operated 13/01/2021, 20/02/2021 and 20/5/2021 **How, when, where the deceased came by his death:** David suffered with severe learning disability, dementia and poor mobility. He was resident in Concorde House. At approximately 0800 on 12th January 2023, he was found to have fallen within his flat. He was unable to get up without significant assistance. At approximately 11:00, the London Ambulance Service was called as he was distressed and unable to walk. He was taken to St George's Hospital and found to have sustained severe pelvic fractures and a fractured and displaced right femur. These were surgically treated on 13th January 2021 with pins and plates to the pelvis and reduction of the femur. This was unsuccessful due to osteopenia and some plates were removed on 20th February 2021. He was discharged immobile to Mc Crae Lane on 25th February 2021.

	From mid-March he developed a wound infection. This was treated in the community by district nurses, GPs and paramedics. The GP advised referral back to the surgeons on 5th May 2021. He was admitted from outpatients back to St George's Hospital on 13th May 2021 and underwent washout and removal of metal work on 20th May 2021. During this procedure, the peritoneum was breached and despite treatment, he died of peritonitis on 4th June 2021. **Conclusion of the Coroner as to the death:** Complications of surgical treatment of injuries sustained in an accidental fall.
4	Extensive evidence was taken during the inquest from multiple live witnesses, written statements, and exhibited reports. Of relevance to this report: David was living in a flat within a complex. There was a communal area. Due to pandemic restrictions no communal activities were taking place and he became increasingly socially isolated, exacerbated further by reduced staff availability. He was able to get up unaided and walk but had coordination difficulties worsened by visual impairment and dementia, such that he required the assistance of 2 persons to move around. On 12th January 2021, there were severe staff shortages such that the manager of the home had worked more than 36 hours without a break and there was only a skeleton crew on duty. This meant that David was not receiving the 10 hours per day of contact time during the days that he had allocated to him and instead was subject to 30 min checks in the day and hourly checks at night. Records suggest that he was checked and found asleep at 0750 hours. At approximately 0800 on 12th Jan 2021, a support worker entered the complex and heard David calling out in a distressed manner. This worker attended David's flat and found David sat on the floor in hall behind his front door. The worker called for assistance from the manager and together they lifted and supported him to walk backwards to the chair in his bedroom. He was latter assisted to his bed. It was only when he refused at about 10:30 to stand off his bed and was distressed that another manager was consulted and medical assistance sought. David was unable to communicate verbally due to his learning disability and had not indicated any particular area of pain on his body. However the injuries that he had sustained in the fall were severe with multiple pelvic fractures and an impaction fracture of the right head of femur. The pelvic fractures involved the hip joint such that the femur was displaced through the pelvic bones into the pelvic cavity. The evidence of the surgeon was that David would have unable to weight bare on the right and could not have been moved without being lifted and with considerable assistance. Those staff that had moved David would have had to have provided this assistance. To move an injured person in this way when they were unable to weight bare was unsafe, could have exacerbated any injuries, and was against the training in moving and handling following a fall that those two staff would have received. Following evidence from the surgeon, I was satisfied that in this particular case, the actions of moving David did not contribute to his death, however I remain concerned.

	The support worker in evidence could hardly remember what training he had received in relation to moving and handling following a fall. At the time, during the pandemic, the training would have apparently been eLearning and video watching for the support worker. The manager was said to be experienced and committed to his work; however both these staff acted outside their training and moved a severely injured man in a way which could have exacerbated his injuries and would have caused him severe pain. It was only when a second manager became involved that clinical care was sought.
5	**Matters of Concern** That the training given to both the manger and the support worker was insufficient and unmemorable, such that it was disregarded when it was required, and that moving injured people in such a way could worsen injury and endanger live.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: Sister of Mr Hemmings: [redacted] St George's Hospital Legal Department, St George's Hospital, Blackshaw Road, London. Sw17 0QT Director Integrated Learning Disability Team, Social Services, 4th Floor Merton Civic Centre, London Road, Morden.

	SM4 5DX. I am also under a duty to send the Chief Coroner a copy of your response. 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	**18th December 2023.**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR** **Telephone:0207 641 8789.**