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:** **1 Corporate Director for Adult Social Care and Public Health, Nottinghamshire County Council, County Hall**
1	**CORONER** I am Mr Michael Wall, HM Assistant Coroner, for the coroner area of Nottingham City and Nottinghamshire
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 Coroner's (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 10 October 2022 I commenced an investigation into the death of Janet Irene SPENCER aged 76. The investigation concluded at the end of the inquest on 21 September 2023. The conclusion of the inquest was: Accident.
4	**CIRCUMSTANCES OF THE DEATH (relevant to this report)** Janet had an unwitnessed fall while in the lounge area of her assisted living accommodation on 30 August 2022. She pressed her call buzzer and notified staff. A support worker attended promptly. Janet was conscious. She reported having hit her head. An ambulance was called and paramedics attended. Janet was transported to Kings Mill Hospital where it was identified that she had suffered an acute subdural haematoma. Surgical intervention was deemed not appropriate. Janet was placed on end-of-life care. Despite a period of a few days when she appeared to improve, she did not recover and remained in hospital until her death some 13 days later. Janet died as a result of a traumatic acute subdural haematoma sustained in the fall, with underlying ischaemic heart disease contributing to but not directly causing her death.
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. Janet had a recent but significant history of frequent falls, some causing serious injury. A care assessment commenced on 6th May 2022 and updated on 10th May 2022, identified that she had reablement potential but further assessment of her needs was required.

On 16th May 2022 she was admitted to the assessment unit at Gladstone House, an assisted living facility. On 25th May she suffered a further fall, fracturing her right neck of femur. She was admitted to Kings Mill Hospital. On 22nd June 2022 a discharge to assess referral form was completed. It included limited detail of her care needs and a single-sentence reference to the fall on 25th May. On 14th July 2022, Janet was discharged to Nightingale Care and Nursing Home. On 18th July 2022 she had an unwitnessed fall there. Fortunately, she sustained no significant injuries on that occasion. On 26th August 2022 Janet transferred to Gladstone House. On 30th August 2022 she suffered the fall which ultimately led to her death.

The evidence heard from staff at both care facilities was consistent in two significant respects: i) they were provided with very little information in advance of the transfer; and ii) the transfer was arranged hastily, which resulted in both facilities having limited opportunity to liaise with each other, or to prepare for and ensure it proceeded smoothly.

I remain unclear as to the precise reasons for Janet's transfer from Nightingale to Gladstone House on 26th August 2022 and why it appears to have been arranged with such haste. No updated care assessment was made prior to transfer.

An error occurred between the care facilities which resulted in Janet not receiving two of her prescribed medications following her transfer to Gladstone House. While this did not cause or contribute to Janet's death, the importance of care facility residents receiving the correct medication needs no emphasis. This error occurred in part because of flaws in the systems of the two care facilities, which I am satisfied have since been addressed. However, the evidence suggests that it was also due, in part, to the haste with which the transfer was arranged and the lack of coordination of it by the social care team.

I heard evidence that the systems in respect of discharges and transfers to Gladstone House have since been improved. I was told that both that provider and the social care team based on site, do now have better systems in place and work closely together to ensure that sufficient information is provided in respect of any referral. However, I was also told that Gladstone House have no power to refuse any referral even if they consider the information provided by social care to be insufficient. Furthermore, the Adult and Social Care Team, Team Manager who gave evidence on behalf of NCC, was (through no fault of her own) unable to assist me with details of any changes that may have occurred more widely within the discharge to assess team since August 2022. I cannot therefore be satisfied that these issues have been adequately addressed.

The MATTERS OF CONCERN are as follows:
(brief summary of matters of concern)

1. The systems in place in respect of discharge to assess patients do not appear to ensure patients are discharged or transferred between care facilities with an adequate and up to date risk assessment and care plan in place.

2. The systems in place in respect of discharge to assess patients do not appear to ensure a smooth transition between care facilities, especially when transfers are arranged at pace. In particular, they do not appear to ensure that all involved have the information they require to contribute effectively to the transfer process.

	Although they did not cause or contribute to Janet Spencer's death, I am concerned that the issues identified above give rise to a risk of deaths occurring if they go unaddressed.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 November 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: 1. Janet's daughters 2. Fosse Healthcare 3. Jasmine Healthcare 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: 4 October 2023** **Michael Wall** **HM Assistant Coroner** **For Nottingham City and Nottinghamshire**