From the Acting Chief Executive and Registrar

Nursing & Midwifery Council

Kally Cheema
Senior Coroner
HM Coroner
Fairfield
Station Road
Cockermouth
Cumbria
CA13 9PT

Ref no: [redacted]

26 September 2024

Dear Ms Cheema

James Reginald Capstick - NMC response to Regulation 28 Prevention of Future Deaths Report

Thank you for sending your Regulation 28 Prevention of Future Deaths Report (PFD) in connection with the death of James Capstick for us to review in accordance with paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. I write to provide a response on behalf of the Nursing and Midwifery Council (NMC).

I am very sorry to hear about the circumstances leading to Mr Capstick's death and I'd like to begin by offering my sincere condolences to his family for their loss. I would like to assure you that we take concerns shared with us very seriously.

We have used the information in the PFD to reflect on the action we can take to address the concerns you have identified and to make sure they do not occur again where we have the power to do so. We set out below the action we have taken to ensure that the professionals on our register are fit to practise safely and professionally and that the public is protected in line with our role.

Your concerns

Your investigation into Mr Capstick's death concluded that on 1 December 2021 Mr Capstick received CPR when not actually in cardiac arrest and as a result he sustained a major chest injury which required a period of hospitalisation. This massive chest injury led to respiratory insufficiency and an episode of pneumonia

which was treated successfully, however the combination of injury and illness led in turn to his death on 1 October 2022.

We understand that you heard that three safeguarding referrals were made in connection with the care provided to Mr Capstick. These related to:

1. concerns raised by the ambulance crew when Mr Capstick was admitted to hospital having sustained a major chest injury;

2. concerns raised by friends who visited Mr Capstick at Westmorland Court in early 2022 about the quality of care given to Mr Capstick;

3. further concerns raised by the ambulance crew about Mr Capstick's appearance in September 2022 when he was admitted to the Royal Lancaster Infirmary.

We have noted that you heard the first two referrals were closed by social services, and the third referral remains open.

In addition to the above, a General Practitioner gave evidence raising concerns about the care being provided to residents at Westmorland Court. He said that care had improved since Mr Capstick's death, but he has to visit regularly to check residents. There is a specific concern about entries made in Mr Capstick's notes as there was clear evidence that examinations entered in the notes were made at times when this was impossible because he was in hospital.

A concern was raised about the absence of a defibrillator in the home at the time of the incident. It appears one has now been installed.

Finally, you have raised with us specifically the concern about the registered nurse in charge of the home on the night of Mr Capstick's injury. There was a statement which said the nurse forgot their basic training and was confused about what to do. Basic checks and signs of life were ignored. You were told that a referral to us had been made and acknowledged and have asked us whether the referral has been closed.

Our role

The NMC is the independent regulator of more than 808,000 nurses and midwives in the UK and nursing associates in England. We're here to protect the public by upholding high professional nursing and midwifery standards, which the public has a right to expect. We maintain the integrity of the register of those eligible to practise and we investigate concerns about professionals. Our Code of Conduct contains the professional standards that registered nurses, midwives and nursing associates

must uphold. We will investigate alleged breaches of the Code when we become aware of them under our fitness to practise process.

We have two clear aims for fitness to practise:

a. a professional culture that values equality, diversity and inclusion, and prioritises openness and learning in the interests of public safety, and

b. nurses, midwives and nursing associates who are fit to practise safely and professionally.

In appropriate circumstances we enforce the standards set out in the Code through fitness to practise proceedings. Fitness to practise proceedings can result in a range of outcomes, ranging from the provision of advice to the registrant by the NMC to removal from the register.

Our response to the concerns raised

We can confirm that our investigations in relation to the concerns raised about the registered nurse in charge of the home on the night of Mr Capstick's injury are ongoing. We have shared your concerns as set out in the PFD with the investigating team. *We have also contacted Westmorland Court for further information and obtained details about the registered nurse's current practice. We have contacted the registered nurse to give them the ability to comment on the concerns and are waiting for their response. We expect to make a decision in the next two to three weeks on whether to progress our investigations further on the basis that we need to take action to protect the public or whether we can close the case on the basis that there are no public protection issues. We also carried out a risk assessment upon receipt of the referral to establish whether urgent interim action needed to be taken to suspend or restrict the individual's practice. We concluded an interim order was not necessary for public protection and was not otherwise in the public interest. We continue to keep this under review pending receipt of new information.*

We have also considered whether the PFD raises any other concerns which we need to act on. We have noted that concerns were raised about the care provided to Mr Capstick generally at Westmorland Court and a specific issue relating to inaccurate entries made within healthcare records. We have noted that at the time of the inquest one safeguarding referral remained open.

In relation to this we have passed this information on to our Employer Link Service (ELS) and to the New Referrals team to make enquiries in relation to these concerns. We will investigate any concerns which fall within our remit through our fitness to practise processes and share information with other organisations if necessary.

Finally, we recognise that our processes can be very difficult for the friends and families of patients who are connected to our investigations. We have a Public Support Service (PSS) to help support people through the process and understand how the investigation process works. Through it, our public support officers can answer individual questions or provide one-to-one meetings and help explain the different decisions that could be made. More information about our PSS can be found here NMC public support service - The Nursing and Midwifery Council. We have referred this case to the PSS team who will reach out to Mr Capstick's family. I am sorry that this has not been actioned until now.

Conclusion

Thank you for raising your concerns with us. I trust that our response sets out the action that we are taking as a result of the concerns raised to improve public health, welfare and safety. If you would like any further information or have any further questions concerning this case or the steps we are taking, please do not hesitate to contact us. Finally, I would like to again offer my heartfelt condolences to Mr Capstick's family.

Yours sincerely

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Acting Chief Executive and Registrar

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