Kally Cheema LLB | Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

Tel: [redacted] | **Email:** [redacted]

Case Ref: [redacted]

25 June 2024

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: 1] [redacted]. Manager, Westmorland Court Care Home, Arnside, Cumbria LA5 0AW.
2] Chief Executive, Care Quality Commission Citygate, Gallowgate, Newcastle-upon-Tyne NE1 4PA.
3] Chief Executive Nursing and Midwifery Council 23 Portland Place, London W1B 1PZ

CORONER

1 I am Dr Nicholas Shaw, HM Assistant Coroner for Cumbria

CORONER'S LEGAL POWERS

2 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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 12 October 2022 I commenced an investigation into the death of James Reginald CAPSTICK. The investigation concluded at the end of the inquest on 21st June 2024. The conclusion of the inquest was a narrative as follows

3 James Reginald Capstick died in the Royal Infirmary, Lancaster aged 83. He suffered from Type 1 Diabetes and Autonomic Dysfunction which required him to be nursed laying down in bed. On 1st December 2021 he was subjected to over 20 minutes of CPR chest compressions when not actually in cardiac arrest, sustaining 10 fractured ribs. 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 1st October 2022. The continuation of chest compressions by a registered nurse in the face of clear indications that her patient was not in cardiac arrest but alive was a gross failure in basic care and can be classed as neglect.

1a Respiratory Insufficiency and Treated Pneumonia

1b Multiple Healing Rib Fractures

1c

II Type 1 Diabetes with Autonomic Dysfunction

CIRCUMSTANCES OF THE DEATH

James Reginald Capstick [Reg] was placed in the care of Westmorland court after a lengthy stay in hospital, he had autonomic dysfunction which cause his blood pressure to collapse if sat up or standing -requiring him to spend virtually all the time being nursed in a flat or semi-recumbent position. He had frequent "absent" periods when he might be unresponsive. On 1st December 2021 a lengthy such period led to a 999 call to the Northwest Ambulance Service. There was great confusion between the call handler and the nurse in charge of the home -demonstrated by transcripts entered into evidence. This confusion led to over 20 minutes of chest compressions being continued on Reg despite clear signs of life -basic checks to confirm this were not carried out. Reg was admitted to hospital having sustained a major chest injury and the ambulance crew raised
4 a safeguarding referral.

Reg returned to Westmorland Court early in 2022, friends who visited were very concerned about the quality of care given and made a second safeguarding referral. I heard at inquest that both these referrals were closed by social services.

Reg became ill in September 2022 and was admitted by ambulance to Royal Lancaster Infirmary, the admitting crew were very concerned by his appearance, apart from illness he was said to be dirty, unkempt and emaciated and dehydrated with dry, caked mouth that did not appear to have had any recent care. A third referral was made and I heard that this remains open. In hospital Reg's pneumonia was treated but he continued to decline and died on 1st October 2022. As a result of the concerns raised the police and ourselves requested a home office postmortem examination

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. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]

5 (1) To Westmorland Court. The General Practitioner who came to give evidence said that care had improved since Reg's death but he still had concerns about care given and had to visit regularly every week to check residents -the only one of six homes he covers that requires this level of support. He said it was a struggle to provide good quality care and felt this report would be helpful -as I stated at inquest it is not intended in any way to be punitive but to put focus on areas that may be improved. A particular concern was clear evidence that examinations entered into Reg's notes were made at times when this was impossible because he was in hospital -this puts into question the reliability of notes generally.

(2) To Care Quality Commission. You requested a note of the outcome of this case and please accept this report as such. I imagine you will be making further enquiries. There

was no defibrillator in the home at the time of this incident although I am told one has now been installed. I was told that it is not a requirement for care homes to have one. If staff in these homes are expected to attempt resuscitation should provision be required?

(3) To Nursing and Midwifery Council. A Registered nurse was in charge of the home on the night of Reg's injury. Her statement told us that she forgot her basic training and had never had to attempt CPR before. Despite clear signs of breathing and resistance to her efforts she continued to be guided by the call handler at NWAS who had been confused by her inconsistent responses to his questions. Basic checks and signs of life were ignored. I was told at inquest that after being stepped down from nursing duty for a while she had had further training and was back in position. I was told that a referral to yourselves had been made and acknowledged but nothing further had been heard, has the referral been closed?

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you and your organizations have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 27th September 2024. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

1] [redacted], friends and designated next of kin for Reg.

2] [redacted], solicitor acting for Reg's estate.

3] [redacted], general practitioner.

8 4] Northwest Ambulance Service.

5] Westmorland and Furness social services department.

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.

2nd August 2024

9 Signature 

Dr Nicholas Shaw HM Assistant Coroner for