**Prevention of Future Deaths Report – Ian George Stanton SIMPSON (date of death: 16 December 2024)**

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| | **Regulation 28 Report to Prevent Future Deaths** |
| | **THIS REPORT IS BEING SENT TO:**<br><br>Chief Executive<br>Barchester Healthcare Ltd<br>3rd Floor<br>The Aspect<br>12 Finsbury Square<br>London<br>EC2A 1AS |
| 1 | **CORONER**<br><br>I am Ian Potter, assistant coroner for Inner North London. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 24 December 2024, an investigation was commenced into the death of Ian George Stanton SIMPSON, aged 81 years at the time of his death on 16 December 2024.<br><br>The investigation concluded at the end of an inquest heard by me on 29 and 30 April 2025.<br><br>The conclusion of the inquest was 'accident'.<br><br>The medical cause of death was:<br><br>1a urosepsis<br>1b long-term catheter following traumatic spinal injury (August 2024) |
| 4 | **CIRCUMSTANCES OF DEATH**<br><br>Mr Ian Simpson fell in August 2024 sustaining a traumatic spinal injury as a result. He required a long-term catheter which increases the risk of urine infections.<br><br>Due to his complex care needs, Mr Simpson was admitted to Magnolia Court Care Home, Hampstead (Barchester Healthcare). At about 09:30 on 16 December 2024, Mr Simpson was found unresponsive by care staff and there |

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| | was a delay in calling an ambulance. He was conveyed to the Royal Free Hospital and found to be suffering from sepsis, secondary to urine infection. Despite treatment, Mr Simpson continued to deteriorate, and he died in the hospital that evening.<br><br>The delay in calling an ambulance did not cause or more than minimally contribute to Mr Simpson's death. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>During the course of my investigation and 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.<br><br>The **MATTERS OF CONCERN** are, as follows:<br><br>1. Mr Simpson was found unresponsive by care home staff at about 09:30 on 16 December 2024, and an emergency ambulance was not called until 10:19. On the evidence in this particular case, that delay did not more than minimally contribute to death; however, it would or should have been obvious to staff that the resident was very unwell and required an ambulance as soon as possible.<br><br>This raises the concern that such a delay, if repeated, places others at serious risk. My concern was compounded by the evidence from the manager (which I did not wholly accept) that it would be reasonable to take this period of time for a nurse to be alerted, assess the resident, and decide whether an ambulance was required.<br><br>2. The notes from the care home were considered in great detail during the inquest, particularly the care notes from the morning of 16 December 2024. These raised significant concern about their adequacy and accuracy. While the deficiencies in record-keeping did not cause or contribute to death in the specific circumstances of this case, I am mindful of the importance of clear and accurate record-keeping to the delivery of safe and effective care more widely.<br><br>The issues included:<br>• an entry that was plainly not correct and therefore gave a misleading impression of interactions that staff had with Mr Simpson at or about the time of his being found unresponsive;<br>• an entry suggesting that Mr Simpson was 'awake and lying in bed', when he had already been found unresponsive some time earlier, suggesting that the entry was either retrospective (and not labelled as such) or simply incorrect;<br>• a series of notes, likely to have been retrospective but not labelled as such, giving a misleading impression of the course of events that morning. |

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| | While I was provided with some evidence that action had been taken in relation to this matter (such as an audit of records), I found that the evidence provided insufficient reassurance that the risk was sufficiently reduced. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 7 July 2025. I, the coroner, may extend the period.<br><br>Your response must contain details of the 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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br>• The family of Mr Simpson; and<br>• Royal Free London NHS Foundation Trust.<br><br>In addition, I have sent a copy of my report to the following, for information:<br><br>• The Care Quality Commission.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest.<br><br>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 | **Ian Potter**<br>HM Assistant Coroner, Inner North London<br>12 May 2025 |