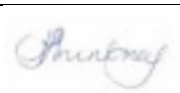
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Belle Green Court Care Home**
1	**CORONER** I am Alexandra Pountney, assistant coroner, for the coroner area of South Yorkshire (West District)
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 11 July 2022 an investigation was commences into the death of June Peel born on 28 June 1933. The investigation concluded at the end of the inquest on 6 July 2023. The conclusion of the inquest was a narrative one and read:- *June Peel died at Barnsley District General Hospital on 22nd June 2022 following an admission from Belle Green Court Care Home. She presented at hospital a displaced fracture to her left distal femur as the result of an unidentified fall. The displaced fracture had been present since at least 3rd June 2022. June's admission to hospital on 8th June 2022 followed a missed opportunity to seek earlier medical attention, and a delay in examining, diagnosing, and treating the injury. June underwent an open reduction and internal fixation during which there were complications contributed to by the formation of a callus. June did not recover from the operation and sadly died on a palliative care pathway.* The cause of death was: (1)(a) Pneumonia (1)(b) Fractured Femur (operated on), Pulmonary Embolus
4	**CIRCUMSTANCES OF THE DEATH** June had been a resident at Belle Green Court Care Home since March 2022 following a relatively complex medical history, including a stroke in February 2022. The care plan for June identified that she was bed bound (to be moved to and from her bed only using a hoist) and that she required two hourly turns to avoid pressure areas. On 29 May 2022, June was incorrectly moved to and from her bed without the use of a hoist for the purposes of being weighed.

	On 3 June 2022, the one of the Senior Healthcare Assistants noted on a body map that there was a lump to June's knee, this was not recorded in the daily communication records, there is no evidence that the information was shared on handover, and it was neither escalated to the Care Home Manager or any medical professional for an assessment. No further action was taken about June's knee until 7 June 2022 when the Care Home Manager happened to notice the injury when she was conducting a bedroom inspection. 111 was called and on 8 June 2022 June was assessed by a GP, an ANP, and eventually taken to hospital where she was diagnosed with a displaced fracture of the distal femur which required ORIF. During the ORIF a callus was found to have developed over the area of the fracture, indicating to the surgeon that the injury was not new. During the procedure, June suffered from blood loss and went on to be diagnosed with a chest infection, suffering from persistently low blood pressure and a fluctuating Hb level. Unfortunately, June was unable to recover from the ORIF operation and was moved onto a palliative pathway. She sadly died in Barnsley District General Hospital on 22 June 2022.
5	**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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. There was a failure to record the injury from the body map in the daily communication records both on 3rd June and 6th June, and a failure to pass that information on at handover (or to document that the information had been passed on). This led to a period in which June was being turned on a 2 hourly basis with a displaced femur fracture. 2. There was a failure to recognise that medical attention was required for June from at least 3rd June 2022, notwithstanding all personal care being conducted by the healthcare assistants. 3. There was a failure to follow the care plan by the healthcare assistants. There has been no investigation done to identify whether this is a condoned or common practice within the home.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 5 September 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: [redacted](son), [redacted] (former care home manager), Barnsley Hospital NHS Foundation Trust, [redacted] (White Rose Medical Practice) and Belle Green Court Care Home. 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 other person who I believe may find it useful or of interest. In this case I have sent a copy of this report to the CQC, the Local Authority and South Yorkshire Integrated Care Board. 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.
9	 **11 July 2023** **Alexandra Pountney** **HM Assistant Coroner**