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. [redacted]** **Interim Chief Executive** **Norfolk Community Health & Care NHS Trust** **Elliott House** **130 Ber Street** **Norwich NR1 3FR** **2. [redacted]** **Director of Community Services – Adult Social Care** **Norfolk County Council** **County Hall** **Martineau Lane** **Norwich NR1 2DH** **3. Ms Anna Dugdale** **Chief Executive** **Norfolk & Norwich University Hospital NHS Foundation Trust** **Colney Lane** **Norwich NR4 7UH**
	CORONER I am Jacqueline Lake, senior coroner, for the coroner area of Norfolk
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 30 December 2013 I commenced an investigation into the death of JOHN HENRY WILSHER, aged 96 years. The investigation concluded at the end of the inquest on 1 August 2014. The conclusion of the inquest was medical cause of death 1a) Subdural Haematoma; 1b) Frailty (Recurrent Falls); c) Old Age and short-form conclusion "Accidental Death".
4	**CIRCUMSTANCES OF THE DEATH** Mr Wilsher was resident in Springdale Care Home ("the Care Home"). His condition deteriorated in November 2013 and he had falls on 18 and 25 November 2013. Mr Wilsher was seen by his GP who referred him to Community Services, Norfolk County Council ("NCC") for assessment, being of the view that Mr Wilsher was not safe at the Care Home due to the falls. The Care Home was not made aware of the referral. Mr Wilsher deteriorated and was seen again by the GP on 27 November 2013 when he was referred to the Norfolk & Norwich University Hospital ("NNUH") for assessment. A CT scan was commissioned which showed right extradural haemorrhage and bilateral subdural haemorrhage which were considered to be several weeks or even months old. It was agreed there was to be no intervention and Mr Wilsher was to be kept comfortable. Mr Wilsher was found to be stable and plans were made for discharge.

	NNUH contacted the Care Home to see whether they felt able to care for him due to his frailty. The Care Home required him to be able to transfer with the aid of one person. He was assessed by NNUH Physiotherapist on three occasions and stated to be able to be so transferred, although it was accepted that his mobility was variable. He was accepted back at the Care Home on this basis. He returned to the Care Home on 7 December 2013. The Discharge Letter gave the Primary Diagnosis as "Right frontal extradural haemorrhage + bilateral subdural haemorrhage" and Secondary Diagnoses and Complications as "Urosepsis". In evidence, the Secondary Diagnoses was inaccurate. The Care Home quickly became aware they could not cope with his mobility and Mr Wilsher's family made arrangements for him to be transferred to a nursing home on 19 December 2013. In the meantime, on 13 December 2013, Mr Wilsher was assessed by NCC Community Services Adult Care, when no further action was taken in view of Mr Wilsher's impending transfer to a nursing home. The result of the Nursing Needs Assessment, carried out on 10 December 2013, was not available as at 13 December 2013. Mr Wilsher died on 21 December 2013.
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 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:- (1) The information contained in the NNUH Discharge Letter is inaccurate; (2) Concerns were raised by the GP and a referral made to NCC Community Services on 25 November 2013 as to the suitability of the Care Home in providing care to Mr Wilsher due to his deteriorating condition. He was admitted to NNUH on 27 November 2013 for assessment and plans were made for discharge to the Care Home. Neither NNUH nor the Care Home were aware concerns had already been raised (prior to a further deterioration in his condition) as to the adequacy of the Care Home to cope with his needs. On Mr Wilsher's discharge to the Care Home it quickly became apparent they could not cope with his needs. (3) An assessment was carried out by NCC Community Services on 13 December 2013 by which time Mr Wilsher had been admitted to NNUH and discharged and plans were already in place for his transfer to a nursing home. (4) The outcome of the Nursing Assessment carried out on 10 December 2013 was not available at the time of the Community Services Assessment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 3 October 2014. 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)

	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.
9	**Date: 5 August 2014** J Lake ..... **Jacqueline Lake, Senior Coroner for Norfolk**