

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. The Chief Executive, Pindy Enterprises Limited, 55 Periwinkle Lane, Hitchin, Hertfordshire, SG5 1TZ</p>
1	<p>CORONER</p> <p>I am Alan Peter Walsh Area Coroner, for the Coroner Area of Manchester West</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 13th November 2014 I commenced an Investigation into the death of Emmeline Hampson, 91 years, born on the 7th September 1923. The Investigation concluded at the end of the Inquest on the 10th February 2015.</p> <p>The medical cause of death was:</p> <p>1a) Subdural Haematoma and Intra Cerebral Bleeding from Fall 2) Warfarin Therapy for Atrial Fibrillation.</p> <p>The conclusion of the Inquest was that Emmeline Hampson died as a consequence of injuries sustained in an accidental fall exacerbated by a recognised complication of warfarin therapy.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>1. Emmeline Hampson died at the Royal Bolton Hospital, Minerva Road, Farnworth, Bolton on the 6th November 2014.</p> <p>2. The deceased had a medical history of Dementia, Osteoporosis, diabetes, Hypothyroidism, Urinary Tract Infection and a history of falls. She had been diagnosed with Atrial Fibrillation and she had a pacemaker fitted.</p> <p>In March 2014 she was prescribed warfarin, which was commenced when she was an inpatient at the Royal Bolton Hospital, Bolton. She was referred to the Anticoagulant Service in Bolton and her first contact with the Service was on the 31st March 2014 to enable her warfarin therapy to be monitored.</p>

3. Between March 2014 and June 2014 Mrs Hampson had a number of falls in her own home, as well as four admissions to hospital. On the 14th May 2014 Mrs Hampson was admitted to Darley Court, Bolton which is an Intermediate Care Unit from the Royal Bolton Hospital, as she required further rehabilitation and a further assessment of her needs.
4. During Mrs Hampson's stay at Darley Court it was agreed with Mrs Hampson and her family that a long term residential placement would best meet her needs and on the 23rd June 2014 Mrs Hampson was admitted to Hazelbrook Christian Nursing Home, Albert Street, Horwich, Bolton, which is owned by Pindy Enterprises Limited of 55 Periwinkle Lane, Hitchin, Hertfordshire, SG5 1TZ.
When Mrs Hampson became a resident at the Nursing Home her mobility was assessed and she was found to require walking frame support and one nurse to mobilise having been deemed to be at a high risk of falls. To address the risk, a fall sensor was placed in her room. The sensor is a device situated within the room so that when a resident gets out of bed a sensor alarm would activate and display on call points within the Home. In addition to the fall sensor Mrs Hampson had a hand held buzzer to alert staff when she required assistance.
5. During Mrs Hampson's residence at Hazelbrook Christian Nursing Home she had a number of unwitnessed falls and on the 1st August 2014 Mrs Hampson was referred to the Falls Service to carry out an assessment in relation to Mrs Hampson's needs to reduce the risk of falls.
Before the risk assessment was conducted by the Falls Service on the 12th September 2014 Mrs Hampson was found to be suffering from a Urinary Tract Infection and there was an agreed plan for there to be a further review two weeks later once the Urinary Tract Infection had cleared.
On the 23rd September 2014 the Falls Service contacted the Nursing Home and the Service was informed that Mrs Hampson had completed her course of antibiotics for her Urinary Tract Infection and she was improving on a daily basis with no further falls.
On the 29th September 2014 the Falls Service again contacted the Nursing Home and was informed that the Urinary Tract Infection had cleared and there had been no further falls. Accordingly Mrs Hampson was discharged from the Falls Service at that time and there was no further contact with the Service by the Nursing Home.
6. On the 4th October 2014 Mrs Hampson had a fall in the Nursing Home whilst going to the toilet, she was found to have a small cut to her eyelid with redness to her knee and a finger injury and she was taken by ambulance to the Royal Bolton Hospital for treatment. There were further falls on the 12th October 2014, the 13th October 2014 and the 22nd October 2014 culminating in a final fall on the 29th October 2014 when Mrs Hampson was found in the corridor of the Nursing Home suffering from a head injury.
7. Following the fall on the 29th October 2014 Mrs Hampson was taken to the Royal Bolton Hospital where a CT scan of her brain showed that there was an acute on chronic subdural haematoma over the right

cerebral hemisphere in the parietal occipital region and in the left parietal occipital region. Neurosurgical intervention was deemed to be inappropriate and on the 1st November 2014 there was a significant deterioration in Mrs Hampson's conscious level and subsequently she deteriorated and died on the 6th November 2014.

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. During the Inquest evidence was heard that
 - i. There was a significant change in Mrs Hampson's mobility and general condition from the 4th October 2014.
 - ii. From the 4th October 2014 there were five falls including the fall on the 4th October 2014 and culminating in the fall on the 29th October 2014. There was no review of the falls risk assessment and no referral back to the Falls Service following any one of the falls between the 4th October 2014 and the 29th October 2014 even though Mrs Hampson's condition had changed and there were recurrent falls.
 - iii. There were no procedures in place at the Nursing Home in relation to the review of risk assessments after a fall or after an obvious and significant change in a resident's condition.
 - iv. There were omissions in the documentation and record keeping at the Nursing Home particularly in relation to falls, and changes in Mrs Hampson's condition, which were witnessed by members of her family on a daily basis.
 - v. The alarm in relation to the activation of the falls sensor placed in Mrs Hampson's room and the handheld buzzer available to Mrs Hampson were the same so that it was not possible to distinguish between activation of the falls sensor arising from Mrs Hampson getting out of bed and Mrs Hampson requesting assistance from a carer, which may simply relate to a request for a drink. Furthermore the alarms activated in the resident's room and an office used by staff. The office used by staff includes a clinician's room where staff prepared medications but the volume of the alarm in the office was insufficient to be heard in the clinician's room, so that a member of staff working in the clinician's room would not be able to hear the alarm.
 - vi. The evidence at the Inquest in relation to the fall on the 29th October 2014 was given by a trained nurse employed by an Agency who did not appear to be familiar with the documentation

	<p>and record keeping particularly relating to risk assessments and there did not appear to be any training of Agency Staff in relation to those procedures. The regular use of Agency staff was of particular concern bearing in mind that the trained nurse from the Agency would be the senior member of staff and the only trained nurse to deal with incidents during the night.</p> <p>vii. The evidence raised concerns that there is a risk that future deaths will occur unless action is taken to review the above issues.</p> <p>2. I request you to consider the above concerns and to carry out a review with regards to the following:-</p> <p>i. The procedures relating to risk assessments, particularly involving falls and the review of assessments after an incident, such as a fall, or a significant change in the condition of a resident.</p> <p>ii. A review of the procedures in relation to documentation and record keeping by members of staff.</p> <p>iii. Training of all staff, but particularly Agency staff, in relation to documentation, record keeping and risk assessments particularly after an incident or a significant change in the condition of a resident.</p> <p>iv. A review of the alarm system in the Home so that there may be different alert sounds to distinguish whether the alarm relates to a falls sensor indicating that a resident has got out of bed or whether the alarm relates to a request for assistance by use of the hand held buzzer, which may be relatively minor and not pose the same risk as a resident getting out of bed. The review should also take into account the volume of the alarm system, particularly in the office and the clinician's room, so that the alarm can be heard by all members of the staff at all times to enable the staff to respond immediately to the activation of an alarm.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion urgent action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by the 1st May 2015. I, the Coroner, may extend the period.</p> <p>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.</p>

8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-</p> <ol style="list-style-type: none"> 1. [REDACTED] – Mrs Hampson’s Son 2. [REDACTED] – Mrs Hampson’s Daughter 3. Bolton Council <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>	
9	<p>Dated</p> <p>6th March 2015</p>	<p>Signed</p> <p>[REDACTED]</p> <p>Mr Alan P Walsh</p>