PRIVATE & CONFIDENTIAL
Pine Tree Court

Response to Coroner's Report

1. Introduction

I respond to the HM Coroner's Report dated 8.6.16 in relation to the death of Gwendoline Betty Clark who refers to the cause of death as respiratory failure, sepsis, pancreatitis, diabetes and bilateral femoral fractures.

The Coroner refers to concerns in point 4 in order to prevent possible future deaths, the matters are as follows:

A) Reporting of the injury that was sustained
B) A 12 hour delay in escalation and safeguarding matters in relation to the allegations that a member of staff had hurt her.

2. Background and Key Facts

The lady concerned had a number of long term conditions including mental health issues resulting in paranoia and there was a history of regular accusations being made against staff as well as others. She also took medication that would of course affect the bone structure.

Betty moved around the home freely, she had suffered previous unwitnessed falls due to her level of independence.

There is no reference that any staff were indeed aware of any falls or occurrences that could have resulted in such injury, this was confirmed by the police investigation nor was there any person on duty that Betty had described who had allegedly caused the harm.

The circumstances remain that there was a delay in requesting aid, a delay in the attendance of the emergency services and delays in reporting the safeguarding matter at the weekend/bank holiday period when the office was closed. This was clearly outside of these times (office hours Monday – Friday 8-5.30pm) hence the delay stated of 12 hours.

3. Actions

An analysis of the report and taking on board the concerns raised through the process, the following actions are necessary:

	Action	By Who/When	Evaluation
i	Re-enforce the safeguarding policy, share with all home staff and use this as supervision, include out of hours reporting process and the manager absence, check staff awareness and knowledge of this process. This also includes an update of the Job Description (RN)	July 2016	Audit PLJ Within August
ii	Include the admission process under general screening for our clients, an assessment to determine	PLJ June 2016	Copy Document

	those more at risk of fractures due to medical problems and lack of sunlight Include relevant signs/symptoms within the monthly health check	[redacted]	Audit of Care Plan [redacted]o check Quality File each month re use of accident log
lii	Re-enforce the home's protocols for unwitnessed accidents and remind staff regarding examination, clinical judgement and pain management – see enc pain chart	[redacted] July 2016	Training Record Analysis
iv	Plan training and supervision refresher first aid particularly to focus on fracture detection	[redacted] 5.7.16	Certification
v	Review the home's management and on-call process both home Manager and regional support manager have now changed	Complete	New registered manager – pending
vi	Intensify the abuse audit and surveys – to complete each month for a 12 month period	[redacted]	[redacted]to check re quality file compliance
vii	Utilise the company escalation tool in order to highlight the practise of the ambulance service particularly in relation to handling techniques – check use of SBAR	Complete and Ongoing	[redacted] to check during care plan audit Sept 16
viii	Conduct a reflective piece, include qualified staff and use for NMC revalidation	Complete June 2016	[redacted]to hold on file and distribute to nurses (own copy)
ix	Refer the issue for external investigation (Bob Taylor) and review possible breeches in conduct as well as NMC code	July 2016	Personnel file
x	Explore the out of hours safeguarding service within Gloucester and circulate details with the home	June 2016	Poster available

[redacted]