REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **Practice Business Manager, Neasham Road Surgery, 186 Neasham Road, Darlington DL1 4YL**
2. **County Durham and Darlington NHS Foundation Trust, Legal Services, University Hospital of North Durham, North Road, Durham DH1 5TW**
3. **Grosvenor Park Care Home, Burnside Road, Darlington DL1 4SU**

1 CORONER

I am Crispin Oliver, Assistant Coroner, for the Coroner area of County Durham and Darlington

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.
(see attached sheet)

3 INVESTIGATION and INQUEST

On 3rd September 2015 I commenced an investigation into the death of Elsie Raper, The investigation concluded at the end of the inquest on 1st March 2016. The conclusion of the inquest was that Elsie Raper died from
1a. Multiple Bone Fractures (of left tibia, left fibula and left femur) treated
1b. Multiple Falls including recent fall on 21st August 2015, Frailty of Old Age and Osteoporosis.
She suffered a fall on 10th June 2015, resulting in a fractured tip of femur for which she was treated. The implications of osteoporosis were not appreciated. She suffered further falls when she was admitted to Darlington Memorial Hospital on 11th August 2015 and on 21st August 2015 when she suffered fractures of the left tibia and fibula which could have been, but were not diagnosed until 25th August 2015. She died at Grosvenor Park Care Home, Darlington on 26th August 2015. The overall conclusion was accidental falls causing fractures.

4 CIRCUMSTANCES OF THE DEATH

Elsie Raper was born on 6th August 1921. She entered the Grosvenor House Care Home, Burnside Road, Darlington in January 2014. She had a diagnosis of osteoporosis from 2007. She was self-mobilising. She had capacity. She suffered a fall on 10th June 2015. This resulted in a fractured tip of femur. She was treated for this. Osteoporosis is mentioned in her medical notes from the GP's surgery, Neasham Road, at this time. She was admitted to hospital and discharged back to Grosvenor House Care Home on 22nd June 2015. She had a further fall on 11th August. There was another fall on 21st August. In her evidence the Care Home Manager accepted that there was insufficient attention given to the possibility of fractures arising in the light of Elsie's osteoporosis. Elsie received on most days attention including examination on 13th August, 15th August, 17th August, 22nd August and 24th August 2015 from nurses from Darlington Out of Hours Service and Darlington District Nursing. She was examined by a GP from Neasham Road Surgery on 17th August 2015 and 24th August 2015. She was examined by a Doctor from Bishop Auckland Urgent Care on 23rd August 2015.It was on 24th August that she was referred to hospital. She was referred for X-Ray. It was the evidence of her daughter of Elsie Raper, that it was she who insisted upon the X-Ray. The evidence of a GP from Neasham Road Surgery was that he accepted that there had been a delay in treating the fractures. The evidence from a Consultant in Emergency Medicine at Darlington Memorial Hospital was that the presentation of Elsie's leg on 25th August, irrespective of the X-Ray results, made for a likely diagnosis of fractures to the

	leg. Elsie's family members stated that she had been in extensive pain after 21st August 2015.
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) That Elsie Raper, being a patient and being subject to regular visits and examination by GP's and nurses, suffered a fracture to her left tibia and left fibula probably on 21st August 2015, which remained undiagnosed until the 25th August 2015. (2) During the period 21st – 25th August she was in extreme pain (3) The cause of death included multiple fractures.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 29th April 2016. 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. I have also sent it to [redacted] who may find it useful or of interest. 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	**DATED** 4/3/16 **SIGNED** [signature] **C.A Oliver, M.A.** **H M Senior Assistant Coroner** **County Durham and Darlington**