H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

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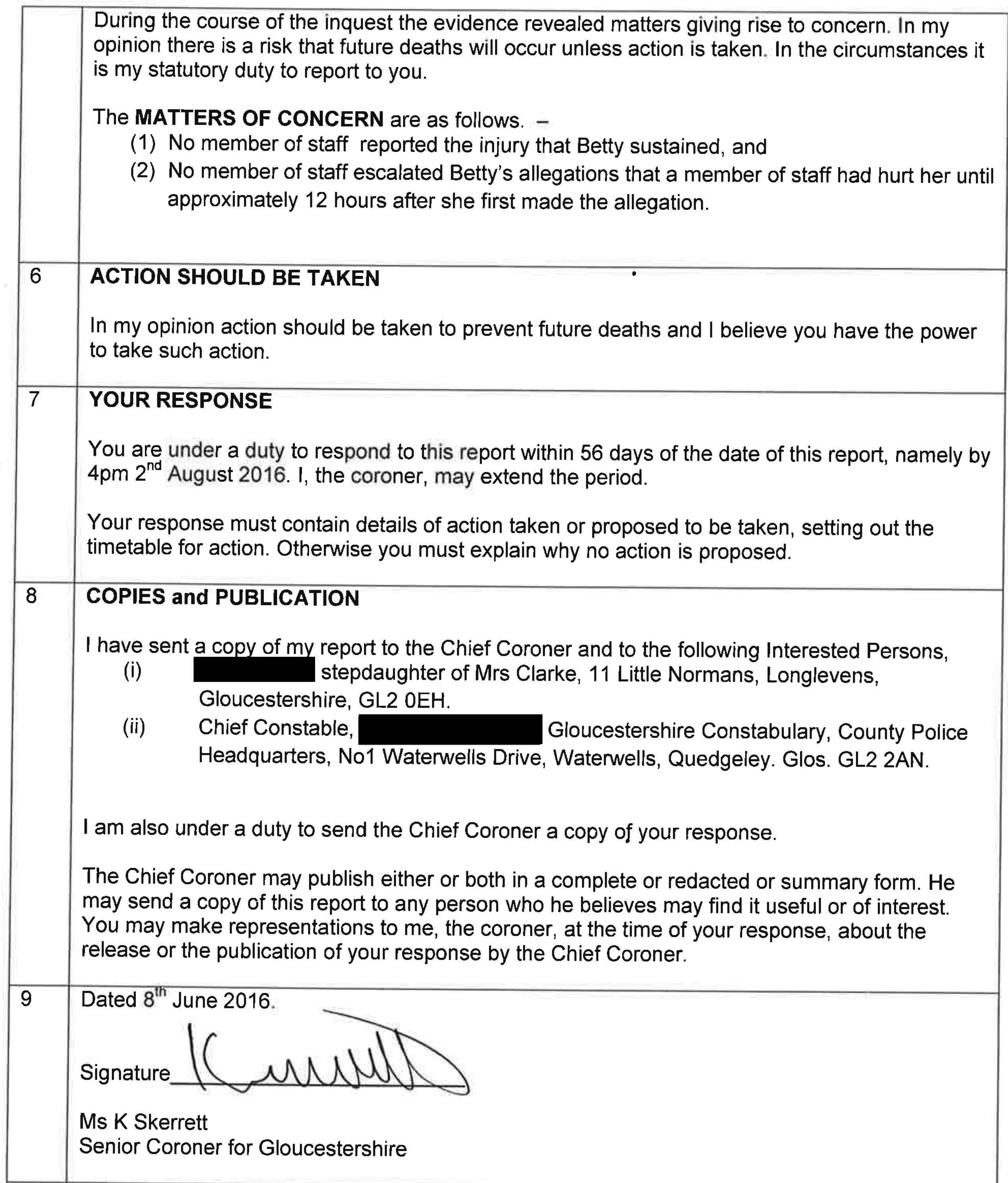
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(i) [redacted] [redacted] Operations Directors, ADL plc., Harewood Court, 89 Harehills Lane, Leeds. LS7 4HA.** **(ii) David Behan, Chief Executive, Care Quality Commission, Citygate, Gallowgate, Newcastle, NE1 4PA [redacted] to [redacted] Head of Inspection for the South Region)**
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 the 2nd January 2015 I commenced an investigation into the death of Gwendoline Betty Clarke. The investigation concluded at the end of the inquest on the 7th June 2016. The conclusion of the inquest was an open conclusion and a narrative conclusion. The medical cause of death was 1A respiratory failure, sepsis, and pancreatitis in a woman with diabetes, 1B bilateral femoral fractures.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Clarke "Betty" was an 89 year old lady who had a significant medical history including cerebral meningioma which was removed in 2011, diabetes, cerebrovascular disease, longstanding anxiety and depression, renal failure and chronic obstructive airways disease. She was a long term resident at Pine Trees Court Care home, Tuffley, Gloucester, having moved there in 2011. She had two admissions to hospital in August and October 2014 with chest related problems. She was able to mobilise using a walking aid and / or with assistance from carers. However her mobility was gradually deteriorating. On the 24th December she was on antibiotics for a chest infection. During the day on the 27th December 2014 she appeared her usual self. During the morning on Sunday 28th December Betty was complaining that she had leg pain and that a member of staff had hurt her. She made several members of staff aware of that fact. No medical review from a doctor was sought. Police were not informed. Emergency services were requested at approximately 21.45 hours. Paramedics arrived at 1.15am on the 29th December, and transferred Betty to hospital. She was admitted to hospital in the early hours of the morning on the 29th December 2014 having sustained injuries to her legs and chest, including multiple fractures. These injuries were caused by a significant incident probably occurring during the morning of the 28th December 2014. The mechanical cause of these injuries whether due to a fall/ how she was handled by a carer remains unclear. It is more probable than not that a member of staff was aware that Betty had sustained a significant injury, and did not report that fact. Police were informed by hospital staff in the Accident and Emergency Department. After admission to hospital she subsequently deteriorated with clinical evidence of respiratory failure and sepsis. Her clinical deterioration was related to her underlying injuries. Her medical history made her more vulnerable to such a decline. She died at 06.43 hours on the 31st December 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) No member of staff reported the injury that Betty sustained, and (2) No member of staff escalated Betty's allegations that a member of staff had hurt her until approximately 12 hours after she first made the allegation.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 4pm 2nd August 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 and to the following Interested Persons, (i) stepdaughter of Mrs Clarke, 11 Little Normans, Longlevens, Gloucestershire, GL2 0EH. (ii) Chief Constable, Gloucestershire Constabulary, County Police Headquarters, No1 Waterwells Drive, Waterwells, Quedgeley. Glos. GL2 2AN. 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 8th June 2016. Signature________ Ms K Skerrett Senior Coroner for Gloucestershire