REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** David Behan, CEO Care Quality Commission 151 Buckingham Palace Rd, London. SW1W 9SZ. [redacted] Manager, Meadbank Care Home, 12, Parkgate Road, London. SW11 4NN.
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 4th and 5th December 2016 I heard evidence in relation to the Inquest touching the death of Mrs Winifred Elliott. **Medical Cause of Death** 1 (a) Bronchopneumonia (b) Immobility and lower limb fractures associated with severe osteoporosis II. Chronic renal failure, dementia. **How, when and where and in what circumstances the deceased came by her death:** Winifred Elliott resided in Meadbank Care Home. She was assessed as non-weight bearing and requiring a hoist for all transfers with the assistance of two persons. A hoist was rarely, if ever used. She was transferred either by being lifted by one person, or

	transferred partially weight bearing with the assistance of a handling belt. On 31/12/2015 she was transferred into bed using a handling belt. This necessitated rotation of her left leg. As a result of this the left leg fractured in four places. The injuries sustained caused or contributed to her death. Despite severe underlying osteoporosis if she had been transferred in accordance with her moving and handling plans , i.e. non-weight bearing this would not have occurred on the balance of probabilities . There was evidence of systemic failings in staffing levels, supervision, and communication that when taken together with the failure to apply the moving and handling plan, constitute a gross failure. The death was therefore contributed to by neglect. She was admitted to Chelsea and Westminster Hospital on 2/1/2016 where despite care the injuries led to and caused her death on 10/1/2016. **Conclusion as to the death** Mrs Winifred Elliott died as a result of injuries sustained during a transfer from her chair to bed using techniques not recommended for her.
4	**CIRCUMSTANCES OF THE DEATH** The evidence was that the staff generally had no time to read care plans and relied on staff handovers for information in relation to moving or handling. Hoists were at times slow to locate and there were often insufficient staff to effect two person transfer. They had been training in relation to the techniques to be employed but staff often ignored that training. There appeared to a culture of collusion with this by some of the more senior staff, for example the nurses. Things do seem to have improved under new management. Evidence was taken as to how it could be made completely clear to staff transferring residents how transfers should be effected for the individual resident, and there was consensus that a written display somewhere effective, e.g. above a residents bed or inside their door could act as an effective prompt to staff, especially for example agency or bank staff. Since transfers are happening in the public areas of the home as well as in residents' rooms, and such information would not be confidential. It would be in the best interest of disabled residents to ensure that such matters could not be confused by staff. Various methods for doing this such as a traffic light scheme were discussed in evidence but it would be for each home to come up with the most appropriate method for them. I was also informed in court that such information was displayed previously but was removed on the instruction of the CQC due to misplaced concerns about confidentiality.
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 information in relation to transferring residents has been removed from display next to the resident e.g. from above their beds or inside their rooms. 2. That the removal of such information has made it harder for busy staff to access such information.

	3. That as such, some residents may be being inappropriately transferred and thus sustaining injuries that may cause to contribute to their deaths as in this case. 4. That all homes should display as appropriate such information. 5. That the CQC should advise all residential homes that they should come up with such a system and implement it forthwith. 6. That the CQC should inspect homes and confirm that such systems are in place.
6	**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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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] [redacted] Triborough Director of ASC Westminster City Council c/o London Borough of Hammersmith & Fulham Extension King Street London W6 9JU [redacted] Director of Social Care (Safeguarding Adults Social Care) Town Hall Wandsworth High Street London SW18 2PU 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	**15th December 2016**  **Dr Fiona J Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**