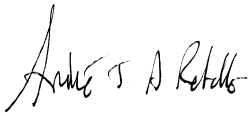
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Liverpool Community Health NHS Trust –** [redacted] **2nd Floor Babbage House** **Liverpool Innovation Park** **Digital Way** **Liverpool** **L7 9NJ** **2. Care Quality Commission -** [redacted]
1	**CORONER** I am André Rebello, Senior Coroner, for the area of Liverpool & Wirral Coroner Area
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 17th January 2017 I commenced an investigation into the death of **Joan RIMMER** who was aged **92** years. The investigation concluded at the end of the inquest on 3rd March 2017. The conclusion of the inquest was Ia Advanced Stage Dementia II Fractured Neck of Femur (treated) On the 3rd March 2017 the inquest concluded that Mrs Rimmer had died from an Accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Joan Rimmer was 92 years of age with a past medical history of dementia, anxiety and stress reaction. She was a resident of Croxteth Park Residential Home which is for residents with early onset dementia. She was not on a deprivation of liberty authorisation.by Liverpool DoLS team. On the 28th November 2016, she suffered an unwitnessed fall. Joan had been left seated in her chair in her bedroom, whilst carers collected what they needed to see to her personal care. On their return they found her on the floor. A falls risk assessment was appropriately carried out. No doctor was called but on 28th November 2016 she saw the community matron as she was complaining of groin pain. He assessed recording his actions in the notes. His later witness statement included additional information with regard to there being no physiological sign of a fracture and that she did not consent to go to hospital for an x-ray. As a result of the persistence of Mrs Rimmer's neighbour a GP was called some 14 days. The GP attended and assessed Joan on 12th December 2016. He reports that she was shouting out but he felt that this was not due to her dementia, aware that she had suffered a fall he referred her for an x-ray. On 13th December 2016 she was referred to Aintree University Hospital and was found to have an intertrochanteric right hip fracture. She underwent a hemiarthroplasty and post operatively she stopped eating and drinking. Fluids and food were encouraged but eventually after discussion with family it was decided to palliate Joan until she sadly passed away on 16th January 2017.
5	**<u>CORONER'S CONCERNS</u>** 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. –

	Though there was no evidence that Mrs Rimmer's death could have been avoided by earlier diagnosis of her fractured hip – the court is concerned that the Community Matron employed by Liverpool Community Health assessed her physiological response to a fracture without taking any physiological readings and further adjudged her to refuse to be x-rayed when a carer witness who was present has explained that the extent of her dementia on the 29th November was so severe she would not understand sufficient to give consent. This in part led to a two week delay before her hip fracture was diagnosed. In another case such standards of nursing could result in an avoidable death not being prevented. The Matron did not attend the inquest due to leave however at the inquest the family were advised by the home that he was retired – the court do not know where the truth lies other than the elderly relatives were keen that the case was concluded without further adjournment.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 5th April 2017. I, André Rebello 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 family of Mrs Rimmer and Croxteth Park Residential Care Home and the CQC 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	 **André Rebello** **Senior Coroner for the** **City of Liverpool & the Wirral Area** **Dated: 3rd March 2017**