DAVID W. G. RIDLEY
Senior Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms Nerissa Vaughan Chief Executive Great Western Hospitals NHS Foundation Trust Marlborough Road Swindon SN3 6BB [redacted] Managing Director Wiltshire Health & Care Chippenham Community Hospital Rowden Hill Chippenham Wiltshire SN15 2AJ [redacted] Corporate Director Adults Social Services (acting) Wiltshire Council Bythesea Road Trowbridge Wiltshire BA14 8JN
1	**CORONER** I am DAVID RIDLEY, Senior Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 19th January 2016 I commenced an investigation into the death of Doreen Helen MILLER and opened her Inquest on Friday 12th February 2016. Doreen was born on 11th November 1931 in Winchester, Hampshire and sadly died at The Great Western Hospital in Swindon during the morning of Wednesday 13th January 2016. She was 84 years old. I concluded Doreen's Inquest on Wednesday 24th May 2017 having heard 5 days of evidence and recorded as regards her cause of death the following:- 1a) Hyperthermia and Bronchopneumonia 2) Left ventricular hypertrophy, hypertension, obesity, type 2 diabetes mellitus, chronic kidney disease and dementia. At a Pre-Inquest Review ("PIR") back in February 2017 I directed that Article 2 of the European Convention of Human Rights was engaged in relation to the investigation and as such when it came to recording a conclusion on the Record of Inquest I recorded a Narrative Conclusion

	which in addition to recording how when and where Doreen died dealt with the central issues that I had previously determined back at the February PIR. A copy of the Narrative Conclusion is attached.
4	**CIRCUMSTANCES OF THE DEATH** Doreen was a vulnerable adult and was in receipt of privately funded care in the community in that her carers would attend during the morning once a day, Monday to Friday. Doreen was housebound with no close relatives although there was a neighbour who, it is highly likely also was a vulnerable adult, would help out with basic shopping from time to time. Doreen was a head strong individual and her family had described her as being careful with money. From about 2011 onwards she had become more and more withdrawn and began to lose interest in relation to her personal hygiene and appearance, which was described by family and others as becoming unkempt. On 20th December 2015 the alarm was raised and paramedics gained entry to her property to discover that Doreen had fallen inside the flat and she was found lying on the floor. She was not confused but she failed a 6CIT Cognitive Test and the paramedic was of the view that Doreen simply did not understand her needs and that she did not have mental capacity. There were also concerns as regards the state of the flat and possible self neglect. There were also concerns that a carer may have stolen money. Doreen herself was admitted to The Great Western Hospital but in the absence of any physical problems arising from the fall she was released to an intermediate care facility at Athelston House in Malmesbury run by the Orders of St John Care Trust. The idea was that they would work with Doreen so as to ensure that her return to independent living in her own home was safe and supported relative to Doreen's needs and of course her wishes. Doreen very soon her arrival at Athelston House began to exhibit extreme toileting behaviour in form of urinating and defecating straight onto the floor. She showed no interest in using the toileting facilities and an assessment carried out by a Senior Nurse at Athelston House on 23rd December 2015 revealed that Doreen was presenting with some degree of confusion and was unsure of her surroundings. Whilst there were improvements insofar as Doreen's personal hygiene was concerned at Athelston House I was satisfied that there was no material improvement insofar as the unusual toileting behaviour was concerned. The preparation for discharge and the making arrangements for discharge were therapy led by personnel at that time employed by The Great Western Hospital although I understand that relevant personnel have subsequently TUPE'd over to Wiltshire Health and Care at some point during 2016 and after Doreen's death. It was clear from the evidence that the Multi Disciplinary Team ("MDT") had concerns in relation to this unusual toileting behaviour although I was satisfied that appropriate advice from Senior Staff was not fed back into the MDT Meeting system and as a consequence the subsequent instruction of a GP to assess Doreen was too generalised in nature and accordingly the very general assessment undertaken did not reveal an underlying mental impairment. I also found that in an attempt to gather background information from family members visiting Athelston House that there was a lack of focus in relation to the nature of the questions which led to an erroneous conclusion being drawn that Doreen's unusual toileting behaviour had been long standing issue and essentially was a lifestyle choice. I found there was no evidence prior to her arrival to support that conclusion to the degree of behaviour that she was exhibiting in Athelston House. I found as a fact that the response from the family member that it was a lifestyle choice and the issue was long standing related to Doreen's unkempt appearance as opposed to the extreme toileting behaviour. The Therapy Led Health Care Team visited Doreen's home and she refused a number of recommendations including the increase in the care package. She did not expand on her reasons and if anything closed down the conversation on the subject. Further advice was sought from the Mental Health Team direct who again appropriately advised that Doreen's own GP visit Doreen at Athelston House. That did not happen and there was never an expectation on the part of the MDT Therapy led members that that would happen before Doreen's discharge. The Therapy led Team concluded that Doreen's leg ulcers could be managed by District Nurses in the community, Doreen herself wanted to go home and they felt that they could do no more for her at Athelston House. Arrangements were made for Doreen's discharge on Monday 11th January 2016. The possible vulnerable adult neighbour was notified as regards Doreen's return as was Doreen's elderly sister who lives 1 ½ hours away but having confirmed as highlighted by the Ambulance Crew that Doreen had no provisions apart from the odd packet of biscuits and cake (that may have been out of date) in the property I found that there was no express request made to the family to prepare for Doreen's return and it was assumed by the health care professional, Mr Roberts, that they would make arrangements between themselves. This was a naïve assumption to make in my view. Doreen returned to her property early afternoon on

	Monday 11th January 2016. Shortly before 0600hrs the following the morning she activated her personal alarm and was subsequently found by paramedics to be sat in a cold, dark flat at a dining table as described in my Narrative Conclusion. Doreen was severely hypothermic and although she was taken to The Great Western Hospital again and appropriate treatment given, she died the following morning on the 13th January 2016.
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. – My Narrative Conclusion as expanded in my summing up detailed a number of failings the majority contributing to Doreen's death. The outstanding concerns which I would like each of the recipients where designated to consider and which are listed below in no order of severity or importance are as follows:- a) **(Wiltshire Council)** When Doreen was admitted to hospital on 20th December 2015 the paramedics made a safeguarding referral to Wiltshire Council. Due to the fact that the admission took place on a Sunday the referral fax was sent to the Emergency Out of Hours Team. I was satisfied having heard a copy of the recording that South Western Ambulance Service also followed up that fax with a telephone call to the Emergency Sevices Team who confirmed that the fax had been received. It appears that in triaging the referral that it was signed off on the basis that Doreen had been admitted to The Great Western Hospital. I heard evidence from a Senior Adult Safeguarding Manager at Wiltshire Council, [redacted] who confirmed my suspicion that in relation to the self-neglect issues that they would ordinarily have been left for the team at Athelston House to address as that from a common sense point of view would be the most appropriate way forward. There however remained the issue as regards the possible financial abuse by a Carer of Doreen. I am concerned here as regards the procedures in place to ensure that safeguarding referrals are properly investigated and whilst I was satisfied that what happened here did not contribute to Doreen's death I am concerned that a safeguarding issue was not followed up and in fact was signed off in circumstances when clearly it should not have been. I would like you to look into this matter with a view to reviewing what went wrong and providing assurances as regards what measures may be introduced to minimise the risk of this happening again in the future or if no action is proposed to be taken, why no action is to be taken; b) **(Great Western Hospital)** In considering the evidence when Doreen was discharged from The Great Western Hospital initially on the 21st December 2015, she was sent with a discharge letter and a 4 page Medivo Summary summarising the paramedics' attendance on the 20th December 2015. Of note that summary did not contain any information that the paramedic had undertaken a 6CIT Cognitive evaluation of Doreen and that she had failed that assessment. One can never guarantee that another document will reflect the information contained in the initial report and therefore a possible way forward could be to ensure in cases where the turnaround through hospital is short that as part of the Discharge Package that it includes a copy of the Paramedic handwritten report that would have been provide to Great Western Hospital when she was admitted. It is however for you to consider how to resolve the concern here that an important bit of information was not provided to the team at Athelston House; c) **(Wiltshire Council, Wiltshire Health & Care and Great Western Hospital)** As a general comment, my view in relation to the quality and substance of case notes was that they were poor in quality. My investigation was hampered due to the fact that the Archiving System at Great Western Hospital for Doreen's therapy led healthcare notes failed in that the notes or at least the scanned images were lost and were not available. Given that some notes were recorded on the Wiltshire Council Care First System and the evidence was that the Healthcare records would not have been significantly different my concerns remain. Crucial and important decisions did not contain any rationale as to why and the basis upon which that decision was being made. As indicated when I

summed up the evidence my view is that recording a rationale can act as a check in relation to the decision making process itself as it forces the author to consider the process and information that has led to that decision being made.

I also have concerns in relation to the way MDT's work and reach decisions. The decisions very much appear to be a consensual decision amongst relevant members of the team as opposed to an individual making the decision based on information provided by relevant team members. There was no leadership. My concern as regards this consensual approach is that no-one actually takes ownership and responsibility for the decision itself and a consensual approach as evidenced in Doreen's case can in my view lead to a situation whereby there is a false sense of reassurance in believing that nothing more could be done for Doreen that in this case led to wrong decisions being taken.

d) **(Wiltshire Health & Care)** As part of the evidence I heard that Doreen in the opinion of an Expert Geriatric Psychiatrist, not only had a mental impairment (cognitive impairment more likely with underlying dementia) but also more importantly that in relation to a serious and complex decision to return home she was of the view, in respect of which I accepted, that more likely than not Doreen could not understand her needs and was unable to recognise the risk of refusing the safeguarding recommendations and that in relation to her decision to return home and those associated decisions that she did not have mental capacity. I indicated in my summing up that this was a difficult case but I feel that the training given especially to the Therapy led members of the team did not sufficiently prepare them to deal with very complicated cases such as Doreen's although that having been said if the advice that had been given had been followed the outcome possibly would have been different. I was however satisfied that had the advice been followed and a capacity test undertaken that Doreen would not have returned home when she did and therefore would not have died when she did. It was also readily apparent to me that members of the Therapy Led Team and particularly [redacted] was unaware that the safeguarding measures, part of the Mental Capacity Act and in particular the ability to secure either and urgent or standard authorisation for the deprivation of somebody's liberty was not available where the individual concerned lives in the community and where their care is paid for privately. As one witness said those cases can be extremely challenging and essentially those trying to do their best for the individual essentially have to wait for the next crisis to occur before they may be given an opportunity to introduce safeguarding measures. Had the mental impairment been recognised and the mental capacity assessment been carried out revealing that she did not have mental capacity in relation to the serious and complex decision to return home and associated decisions concerning additional safeguarding measures and if Doreen still wished to return home then it may have been in her best interests to have considered Deprivation of Liberty Safeguarding Order. I would hope that this particular case in particular could be used as a specific training case by all organisations involved but I have concerns that there were material gaps in individuals' knowledge bases.

e) **(Wiltshire Health & Care)** Having commenced a Coronial Investigation I tasked Coroners Officers to make a number of enquiries on my behalf and that included securing statements. As part of documentation that was disclosed by Wiltshire Health and Care was an email from Intermediate Care Lead Carol Langley-Johnson, her email sent to Acting Coroner's Officer [redacted] on 4th July 2016 contained a final paragraph that said "*I have no concern about the standards of care provided by my team, I have read their statements and feel that this is a fair representation of rehab she received*". As will have been abundantly clear from reading this report and my Narrative Conclusion I did not share the same view as Ms Langley-Johnson and I am concerned and surprised that prior to the Inquest Final Hearing that no attempt was undertaken to carry out any form of Serious Case Review by Wiltshire Health and Care, formerly Great Western Hospital. I am concerned as regards the system in place that will pick up serious incidents for review and the mechanism in place to undertake investigations with a view to learning points being highlighted, the consideration of procedural changes and the implementation of any changes including additional training needs where required. I am concerned that there may be other incidences where there are learning points where

	there has not been a review and whilst those incidents may not have resulted in the death of an individual that the learning points have not been recognised and therefore there is the potential out there for repetition and in extreme circumstances repetition of dangerous practices that may lead to death and the involvement of me and my office. I would ask respectfully that those recipients of this letter where indicated in brackets consider the concerns I raised and deal with them
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 21 July 2017. 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] Locality Team Manager, Adult Social Care, Wiltshire Council, Monkton Park, Chippenham, Wiltshire SN15 1ER . Manager, Athelston House, Priory Way, Burton Hill, Malmesbury, Wiltshire SN16 0FB and [redacted] [redacted]The Great Western Hospital, Marlborough Road , Swindon SN3 6BB [redacted]rincipal Solicitor/Manager, Transcare Law, 1 Admiral Way, Doxford International Business Park, Sunderland SR3 3XP [redacted] New Court Surgery, Borough Fields, Royal Wootton Bassett, Wiltshire SN4 7AX [redacted] Malmesbury Primary Care Centre, Priory Way, Malmesbury, Wiltshire SN16 0FB and Medical.London@Medicalprotection.org – ref:LH983999 I have also sent it to Care Quality Commission - CQCInquestsandCoroners1@cqc.org.uk and [redacted] Chair, NHS Wiltshire Clinical Commissioning Group, Southgate House, Pans Lane, Devizes, Wiltshire, SN10 5EQ 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 26 May 2017 Signature_____ Senior Coroner for Wiltshire and Swindon