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. [redacted], Corporate Affairs Manager, Safehands Ltd**
1	**CORONER** I am Alan Anthony Wilson, senior coroner, for the coroner area of Blackpool & The Fylde
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 12th September 2017 I commenced an investigation into the death of Dennis Geoffrey Oldland. The investigation concluded at the end of the inquest on 15th September 2017. The conclusion of the inquest was a narrative conclusion as follows: "At approximately 1030 pm on 4th November 2016 Dennis Oldland was visited at his home address by a care worker. The visit lasted approximately seven and a half minutes. It was not appreciated that Mr Oldland was confused. When the carer departed he was seated in an armchair in his living room in close proximity to a fire. The television was on. He remained seated there overnight until 1045 am the following morning when he was found to have a reduced level of consciousness and having suffered a significant burn injury to his left leg. He was transported to hospital by ambulance. On 11th November 2016 he was assessed to be sufficiently frail that he was appropriately made the subject of a Do Not Attempt Cardiopulmonary Resuscitation Order. On 9th December 2016 he had a stroke. His level of consciousness having reduced markedly an appropriate decision was taken to provide end of life care and he died at approximately 1800 hours on 14th December 2016. " The medical cause of death was: 1a Stroke and advanced frailty 2 Burn injury[5th November 2016]
4	**CIRCUMSTANCES OF THE DEATH** Prior to late afternoon on 4th November 2016 Mr Oldland was mobile – he could rise from the chair in his lounge unaided, could walk around his lounge unaided, and upon leaving that room he could walk around his home, including up and down the stairs to & from bed and he used a walking stick to assist him when needed. When he received his last care visit for the day on the evening of 4th November 2017, the carer knew that visit was expected to last at least 25 minutes but in actual fact she

	was in Mr Oldland's house for no more than approximately 7 and a half minutes. Although the length of that visit was affected by the fact she felt uncomfortable about Mr Oldland being naked from the waist down upon her arrival, irrespective of any discomfort she felt her departure from the property after such a brief period was not felt to be justified or appropriate. CCTV footage of the incident suggested that by the time she left the property she had little idea how Mr Oldland was and had engaged in very limited conversation with him, if any. Athough the court found that so far as Safehands Lltd is concerned there was nothing that ought to have indicated to the company that a carer would have conducted such an inadequate visit, it was clear from witness evidence from other carers that they felt that there are circumstances in which a visit of less than the full anticipated duration may not take place if for example the carer had completed the tasks expected of that carer, had assessed how the service user was, and appeared content for that carer to depart, particularly if it appeared that the service user appeared to prefer to do be doing something else at that time such as watching television. Mr Oldland had been confused at the time of the visit on 4th November 2016 and had the visit been longer and had the carer taken some time to converse properly with him and spend longer in his company even if for the most part he may have been simply appeared content to be watching television then she may have appreciated that such was his confusion that it may not have been safe to leave him partially clothed in close proximity to the fire. Prior to that date it was accepted by all that Mr Oldland was someone who was independent and regularly preferred to remain in his armchair of an evening after a visiting carer had departed at the end of the last visit of the day and watch television in front of the fire. He almost always preferred the fire to be on and it was the view of this court that it was not expected that the carers were to insist he went to bed and turned the television and the fire off before doing so. Indeed, prior to that date it was not felt there was a risk of Mr Oldland becoming confused, becoming only partially clothed, remaining in his chair overnight and receiving a significant burn injury. His confusion was probably the result of a transient ischaemic attack. He remained at home until the following morning when he was found by another carer and then taken to hospital by ambulance. In due course although hospital doctors were in the process of treating his burn injury appropriately, the injury was deep and did play more than a minimal role in his death. By 11th November 2016 he was made the subject of a do not attempt cardio-pulmonary resuscitation order on the grounds of advanced frailty by a consultant geriatrician. On 9th December 2017 he suffered a stroke and with his level of consciousness remaining significantly reduced he died on 14th December 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 could 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) a. A care worker – who was an impressive witness and clearly trying to assist the court - gave evidence at the inquest and when asked if there were circumstances which in her view could justify a visit to a service user lasting less

	than the allotted time period responded on the basis that such visits can be justified if the care worker's tasks have been completed, has assessed how the service user is, and if the service user appears content for the carer to depart. b. I have a concern that limiting the amount of interaction creates a risk that a potential risk or a concern about the service user's welfare may go unnoticed. c. In contrast, were carers to ensure they converse with vulnerable service users and remain at the location for the expected duration of the visit, then a potentially concerning issue is more likely to come to the carer's attention and they can respond appropriately. d. In summary I have a concern that carers may leave a service user's home prematurely, confident that the service user appears well, but in reality unaware of an issue that would have, with more time and interaction, become apparent.
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 14th November 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: The family of Dennis Geoffrey Oldland Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust Chief Executive, Blackpool Council Care Quality Commission 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	**18TH September 2017** A. A. Wilson **[Senior Coroner]**