REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] Interim Chief Executive, Borough Care, Head Office, 9 Acorn Business Park, Heaton Land, Stockport SK4 1AS.

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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

INVESTIGATION and INQUEST

On 13th June 2017, Chris Murray, Assistant Coroner for Manchester South, opened an inquest into the death of Kathleen Smith who was aged 80 when she died at her care home on 4th June 2017. The investigation concluded at the end of the inquest which I heard on 20th October 2017.

The conclusion of the inquest was that Mrs Smith died as a result of a stroke whilst being in the advanced stages of dementia. Whilst this is a natural cause of death, the inquest concluded her death was contributed to by a hip fracture sustained on 12th April 2017 at her care home when she fell to the floor having been pushed by another resident. At the end of the inquest, I recorded a Narrative Conclusion to this effect.

CIRCUMASTANCES OF THE DEATH

Mrs Smith first moved to Lisburne Court Care Home in Stockport in May 2016, as a result of needing increasing support due to Alzheimer's dementia.

On 12th April 2017 whilst in the dining area, Mrs Smith was pushed to the floor by another resident, resulting in a right neck of femur fracture.

Mrs Smith was taken to Stepping Hill Hospital, where on 15th April 2017 she underwent a right hip hemi-arthroplasty. In the aftermath of the surgery, Mrs Smith was diagnosed as having delirium and progression of Alzheimer's disease. Her diet remained poor and her fluid intake limited.

Despite some limited signs of improvement whilst in hospital, following a meeting with Mrs Smith's family, a decision was made to discharge her back to Lisburne Court for palliation.

Mrs Smith returned to Lisburne Court on 5th May 2017. She sadly died on 3rd June 2017.

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.

In the course of the inquest I heard evidence that, whilst the management team at Lisburne Court had notified Greater Manchester Police and Stockport Metropolitan Borough Council of the incident in which Mrs Smith sustained injury on 12th April 2017, neither the family nor Borough Care's corporate risk function had been notified of the circumstances which led to Mrs Smith's hip fracture. This latter point raises a particular concern as to Borough Care's ability to undertake any meaningful investigation into the circumstances of Mrs Smith's injury, with a view to deriving learning for the benefit of other residents.

The inquest also heard evidence that Lisburne Court's process for internal incident reporting and escalation largely fell to an individual manager who has since left Borough Care's employment. It was a matter of concern that notwithstanding this fact, no audit or similar review exercise as to incidents or issues at Lisburne Court had been undertaken since the departure of the individual manager in question, despite the evidence of the Interim Head of Care that some resident documentation and computer files has allegedly gone missing.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th January 2018. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

1. [redacted] (Daughter of the deceased);
2. [redacted] (Daughter of the deceased).

I have also sent it to Stockport Metropolitan Borough Council, and the Care Quality Commission who may find it 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.

14/11/2017

Signature 

Chris Morris HM Area Coroner **Manchester South**