for Staffordshire (South)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted]-Care Home Manager (sent to home address as care home now closed)** **2 [redacted]–Independent Futures** **3. [redacted]–Community Disability Nurse**
1	**CORONER** I am Margaret Joy Jones, Senior Assistant Coroner for Staffordshire (South)
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 06/01/2017 I commenced an investigation into the death of John Keith Edwards, 64. The investigation concluded at the end of the inquest on 10.1.2018. The conclusion of the inquest was: **Accidental death contributed to by neglect**
4	**CIRCUMSTANCES OF THE DEATH** **The deceased was 64 years of age and had a medical history which included down's syndrome, heart pacemaker, dementia, Osteoporosis and celiac disease. He was admitted to Southwinds Care Home Burntwood for respite on the 1st October 2016. His falls risk assessment was poor. He suffered 2 slip falls on the 2nd and 3rd October 2016 and 2 seizures on the 3rd October 2016. No medical help was sought and thereafter he was largely wheel chair bound. Significant bruising was noted on the 8th October 2016. Subsequent documentation was retrospective and poor. An out of hours GP was called on the 13th October 2016. His symptoms were poorly relayed to the GP and he was told only about a suspected chest infection. He prescribed prophylactic antibiotics and advised urgent referral to his own GP. This was not done. There was no evidence of a skin care plan. District nurses were called in on the 24th October 2016 to attend to a significant pressure sore. He was found to be screaming in pain and with obvious deformity of lower limbs. He was admitted to Good Hope Hospital and diagnosed with an old left acetabular fracture, an old displaced right neck of femur fracture, bilateral pulmonary embolus, possible liver laceration, pneumonia, congestive cardiac failure , sacral and left thigh ulceration. The original fractures had occurred well before his admission to the home. However his subsequent rapid decline was due to a combination of the subsequent falls, seizures, reduced mobility and development of pressure sores in the home. He was discharged from the hospital to Hoar Cross Nursing Home Abbotts Bromley where he died at 22.41 hours on the 19th December 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. –

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	(1) Southwinds Care home did not appear to be able to cope with Mr Edwards complex care needs. Consequently the original placement appeared to be inappropriate **(2) The Care Home had an inadequate policy to deal with falls and no policy for pressure sore prevention and care** **(3) Care Home staff applied a seizure policy which was not specific to the resident.** **(4) Care Home staff failed to seek medical assistance following seizures.** **(5) Care Home staff failed to deal with significant bruising which developed 8 days after admission to the Care Home.** **(6) Care records were retrospectively filled in.** **(7) Staff and management failed to recognise and seek help for the residents deteriorating condition other than by way of an out of hours attendance when the GP was given minimal information and the urgent follow up request was not done.** **(8) Staff were unaware that medication brought in by the family was available to Mr Edwards, therefore it was not given. None was sought from the GP.** **(9) Non patient specific dressings were used on pressure sores.** **(10) A non-patient specific mattress was used on his bed.** **(11) Visits by the placement officer and disability nurse failed to identify Mr Edward's deteriorating condition.**

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 8th March 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons • [redacted]**–sister of the deceased** • **Care Quality Commission** • [redacted]**–Staffordshire Police** **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 10 January 2018 Signature_____ for Staffordshire (South)

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