REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Mr Justin Hutchens, Chief Executive, HC-One Ltd, Southgate House, Archer Street, Darlington, County Durham, DL3 6AH

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 March 2018, Rachel Galloway, Assistant Coroner, opened an Inquest into the death of Mrs Doris Douthwaite, who died at Willow Wood Hospice, Ashton-Under-Lyne on 26th February 2018, aged 93 years. The investigation concluded at the end of the Inquest which I heard on 28th August 2018

At the end of the Inquest, I recorded a narrative conclusion that Mrs Douthwaite died as a consequence of bronchopneumonia. Whilst she would have been at risk of developing this condition in any event, it is likely that her death was contributed to by a hip fracture sustained in a fall at her care home.

CIRCUMASTANCES OF THE DEATH

Mrs Douthwaite had a complex medical history which included atrial fibrillation, a previous myocardial infarction and type 2 diabetes mellitus. She was formally diagnosed with vascular dementia in 2016.

Mrs Douthwaite's mobility had become somewhat impaired in recent years – a particular feature of this was falls from time-to-time associated with her being either light-headed on standing up or her legs simply giving way.

In December 2017, Mrs Douthwaite moved Greatwood House Residential Care Home in Denton, Tameside. Greatwood House is currently owned and operated by HC-One Ltd.

Whilst at Greatwood House, the evidence before the court was that Mrs Douthwaite had 3 falls between 11th – 13th February 2018. The first occurred whilst she was walking with a Zimmer frame (but without assistance from a carer, contrary to the requirements of her care plan), the second in circumstances when she and other residents had been left unsupervised in a communal area whilst the staff on duty attended to another resident, and the third when she was found on the floor near her bed.

Mrs Douthwaite was subsequently taken to hospital where a hip fracture was diagnosed, and further tests demonstrated that she was likely to have also suffered a stroke in the preceding weeks. As a

result of raised inflammatory markers, Mrs Douthwaite was treated with intravenous fluids and antibiotics.

In hospital, it was considered that Mrs Douthwaite was not fit enough to withstand an operation to fix her hip fracture, and she developed pneumonia despite antibiotic therapy.

Mrs Douthwaite was moved to Willow Wood Hospice, where she died on 26th February 2018. The medical cause of her death was:-

1a) Bronchopneumonia;

II) Vascular dementia, myocardial infarction, cerebrovascular accident, fractured left hip

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. –

1. The evidence before the court suggested that at Greatwood House, vulnerable residents including residents with dementia such as Mrs Douthwaite, may be left unsupervised at times in communal areas by carers undertaking other tasks. The evidence before the court was that there are currently no clear written requirements in force across HC-One's homes mandating the attendance of a colleague to monitor the communal area in question before leaving it unattended;

2. The Risk of Falls Assessment Tool currently used across HC-One's homes was demonstrated in court to be unclear and susceptible to different interpretations. When asked about it in the course of her evidence, HC-One's Area Director was not aware as to whether or not this Assessment Tool had recently been benchmarked as against others used within the industry;

3. Notwithstanding the fact Mrs Douthwaite had 3 falls over the course of as many days in February 2018, HC-One had not, as at the date of the Inquest, undertaken any investigation into the circumstances of these. The absence of any investigation by HC-One in this respect represents a missed opportunity to ascertain if any learning can be derived from these incidents for the benefit of other residents.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th October 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 Mrs Douthwaite's family. I have also sent a copy to Lester Aldridge, HC-One's legal representatives.

I have sent a copy of my report to the Care Quality Commission and Tameside Metropolitan Borough Council 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.

Dated: 3rd September 2018

Signature:

Chris Morris HM Area Coroner, Manchester South.