REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] Directors of Zinnia Healthcare Limited • Suite 10, 792 Wilmslow Road, Manchester, England, M20 6UG Copied for interest to: • Chief Coroner • Next of kin • CQC
1	**CORONER** I am **Nigel Meadows HM Senior Coroner for the Manchester City area.**
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	**INQUEST** I concluded the inquest into the death of Veronica Gregory on 28th November 2018 and recorded that he/she died from: 1a Hospital acquired pneumonia b Right neck of femur fracture (operated) c ii. Acute kidney injury
4	**CIRCUMSTANCES OF THE DEATH** The deceased was 83 years of age who suffered from dementia, lacked Capacity and was living in Yew Tree Manor Nursing and Care Home which is owned and operated by Zinnia Healthcare Limited. She moved into the premises in October 2013 but her condition so far as dementia was concerned continued to deteriorate. Although she was still mobile she suffered a number of falls over a period of time. On 14th September 2017 she fell again but this time suffering traumatic injuries to her face. It does not appear that a doctor was called to assess her and there were no records of any detailed physical examination or recorded observations for a period of time thereafter. The family were concerned about the apparent lack of review of any

falls risk assessments together with supervision by care staff of the deceased. The deceased was in the habit of wondering around the care home during the majority of the day but also at night and was largely unobserved by the care staff during the day.

Her care plan was apparently last reviewed on the 22nd August 2017 and was due for further review on the 11th October 2017. The deceased was assessed as lacking capacity and would require a DoLs. At times the deceased could become aggressive. On the 14th September 2017 a document titled 'Personal risk assessment and behaviour development plan' was completed. But this simply dealt with the deceased becoming spontaneously agitated sometimes aggressive but not the risk of falls. On the 16th November 2017 the deceased was in the lounge area of Yew Tree Manor when she had what was described as an unwitnessed fall On 22nd August 2017 she was assessed as being at high risk of suffering falls and this was a long term issue. There are no records of the care plan and risk of falls being reviewed and reassessed between then and the 11th October, nor between 11th October and 16th November.

The current Home Manager agreed and accepted that the records in this respect were inadequate and incomplete.

On the 16th November 2017 during the late afternoon at about 1700 hours one of the other residents in the home indicated to one of the care staff that the deceased 'decided to sit on the floor' but that she did not fall This was not recorded in the daily records. Whatever incident occurred this was unwitnessed by any member of staff but the other resident was then able to provide any other particulars. The deceased was unable to explain what if anything had happened. She was then examined by a RGN Nurse who recorded in an accident report form that no physical injury was observed or that the deceased was apparently in pain No specific recording was made of exactly what examinations and assessments were performed nor of any neurological assessment or any plan for continuing observations. It was not recorded that the deceased was assessed for 'leg shortening' It was recorded that she was 'assisted up' but not to where For example her feet, a static chair or to a wheelchair. The deceased's family were not advised about the incident nor was there a request made of further observations overnight and no doctor was called. The then home manager has indicated in a statement that the deceased 'was observed during the night for PAD checks every 2-4 hours and there were no unusual occurrences'. However, there are no written records of that

The current Home Manager agreed and accepted that a GP should have been called at that stage

The following day on the 17th November 2017 the deceased's son visited the home in the morning, at about 11 00 a m , and on arrival was told that the deceased was in pain and it took some time for the staff to get her up and ready for the day. She was brought to see her son in a wheelchair and he noted that she was obviously in pain. It was recorded in a report to the CQC that she showed no signs of pain or discomfort until she was assisted to stand after getting washed and dressed at about 11.00 a.m. This was not recorded in the daily records The deceased would usually have been checked on and assisted to get up much earlier in the morning and then

dressed This may have been at 8.00 a m She was apparently suffering bruising to the face. The current Home Manager agreed and accepted that the GP should have been called as soon as that injury was noted

The Home Manager at that time had called the GP to attend. On his arrival her performed an initial examination and immediately directed that an ambulance be called urgently. She was then taken to Wythenshawe hospital where she was diagnosed as suffering from a fractured neck of femur She underwent operative treatment on the 19th November 2017 which was technically successful but post operatively her condition deteriorated because she developed pneumonia. This was recognised and treated but her condition continued to deteriorate and she died on the 23rd November 2017

At the inquest hearing on the 28th November 2018 the newly appointed care home manager attended but no other senior member of management staff nor any Director of Zinnia Healthcare Limited.

The current Home Manager acknowledged that all qualified nursing staff have the obligation under the NMC Code of Conduct to make accurate and full clinical records of any examination or decision as to treatment They should also be aware of the NICE Guidelines on the identifications and management of head injuries

There were no clear records of the deceased's usual level of observations between about 9 00 a.m. and 6.00 p.m on a daily basis The examination apparently performed by the nurse on 16th November did not specify exactly what was involved and results, nor dealing with possible "leg shortening" The current Home Manager agreed and accepted that the clinical records were inadequate and insufficient Thereafter, they was a lack of detailed observation records from the early evening until the following morning. There was no clear record of exactly which member of staff found her and the precise time.

On 17th November when the deceased was brought to the office, the Home Manager should have been aware of the previous day's incident because of the completed accident report form. This should have resulted in an immediate call to the doctor and a review of the deceased's condition, but this was not done.

The current Home Manager indicated that between September and November 2017 there were inadequate numbers of staff employed at the Home and this led to a delay in reviewing every and reassessing care plans for all residents. She accepted that it is for the owners and operators of the Home to secure provision of adequately trained staff in the required number. She accepted that there were a number of failures to provide basic nursing and general care for the deceased In addition the recording keeping was very poor. She indicated that further steps had been taken to improve matters but there was a lack of specific detail.

The current Home Manager indicated that they had now moved to a computer based recording system and then some training has been given to staff about this. However, she readily accepted that whatever recording system was operated it was entirely dependent upon the full, accurate and timely entry of all appropriate information.

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· 1. Inadequate and insufficient care plans including specific risk issues together with, a lack of appropriate review and reassessment either following an incident or as a matter or general practise. 2. A failure to have appropriate daily observation records fully completed. 3. A failure to ensure that full and appropriate clinical records of any physical examination and action taken as a result being made. In addition, failure to refer to appropriate NICE Guidelines and comply with them. 4. A failure to ensure sufficient numbers of adequately trained staff at all times. 5. A failure to ensure that agreed protocols for seeking specific medical help and assistance were followed in respect of specific incidents. 6. A failure to ensure adequate supervision and governance of all relevant staff 7. A failure to be able to demonstrate, even at the time of the inquest hearing, specifically what changes in practice and procedure had been made, and how the governance of the Home was being managed and regular checking of the quality of all records now being kept.
6	**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
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **Monday 4th February 2019**. 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 Interested Persons I have also sent it to organisations 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	**DATE:** **NAME OF CORONER:** 6th December 2018 **Nigel Meadows** HM **Senior** Coroner for Manchester City Area **Signed:** **Nigel Meadows**