ROSSMERE PARK
CARE CENTRE

1 Greenock Road
Hartlepool
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16 JUL 2019

10th. July 2019

Miss C Bailey
Senior Coroner for Teesside & Hartlepool
HM Coroner's Office
Middlesbrough Town Hall
Albert Road
Middlesbrough
TS1 2QJ

Dear Miss Bailey,

**Inquest into the death of the late Gloria Elizabeth MEKINS**

This reply is in response to your letter of 28th. May 2019, which was sent to Rossmere Park Care Centre with a Regulation 28 Report, in which you request details of any actions taken by the Home regarding your concerns noted in the Report.

Although I have addressed your Matters of Concern below, the first point I must make is that your assertion in point 4 – Circumstances of Death – that "staff attended and believed she was choking" is incorrect as there is no evidence in any of the staff statements (which were written soon after the event) that **ANY** staff believed she was choking at the time of the incident.

**MATTERS OF CONCERN:**

1. The Health Care Assistant who initially discovered Mrs Mekins choking carried out no first aid, nor did she take any action to try and clear Mrs Mekins' mouth or help improve her breathing e.g. back slaps or Heimlich manoeuvre.

The first point I would like to make is that the HCA who was first on the scene **DID NOT DISCOVER MRS MEKINS CHOKING.** Her statement shows quite clearly that when she attended Mrs Mekins' room, which she did within seconds of the buzzer being sounded, there were no coughing or choking sounds or any indication that the lady was choking. Mrs Mekins was sitting in her chair but was not breathing.

The HCA had received First Aid training but, perhaps because this was the first time she had discovered anyone not breathing, chose to ring the Emergency buzzer and summon further help and/or attract the attention of the Nurse on duty. The Senior HCA arrived at Mrs. Mekins' room shortly before the Nurse and checked her pulse – but there was no pulse to be found. When the nurse arrived – some 30 second later - she observed that the lady was cyanosed and not showing signs of breathing. She checked Mrs Mekins' airways with a loop and scoop motion and gave back slaps but neither of these actions showed evidence of choking. She requested a member of staff to ring 999. When the paramedics arrived, they also confirmed the airway was clear of any obstruction

2. There was confusion as to the existence of a DNACPR and this led to a delay in the provision of first aid.

The home accepts that the HCA was not aware that a DNCPR was in place, but for the reasons explained above, did not attempt CPR. The Senior HCA who was next at the scene was aware of Mrs Mekins' DNACPR notice but needed to confirm the Notice was still in date which it was. It was during the time of this check that the nurse carried out her own actions and, being advised a DNACPR was in place and was extant, requested an ambulance.

Staff are advised which resident has a DNACPR Notice by means of a whiteboard within the Nurse's office at Rossmere Park Care Centre – with the same facility in the Senior's office on the Ground Floor. This shows against each resident's room, whether a DNACPR is in place and the date it expires. The Daily Handover sheets also show clearly against each room which resident has a DNACPR.

Immediately following the Coroner's Inquest on 17th. May 2019, the home implemented a new system to notify staff which residents hold a DNACPR Notice. Where a DNACPR is in place for a resident, a Blue Butterfly has now been attached to the outside of the resident's room door near the resident's photograph. An Advice notice (that a DNACPR is in place) in bold, red writing has also been placed at the front of the black folder kept in each resident's room where staff write daily and visual observations and so is in constant use by all care staff.

3. The Care Home had not undertaken an internal investigation into events surrounding Mrs Mekins' death and have not identified the above issues, nor have they attempted to remedy them.

Immediately following the death on 2nd October 2018, I asked all staff involved to write a Witness Statement whilst the events were fresh in their minds as I was due to go on annual leave the next day. Whilst I was away, a call was received from your office advising that Mrs Mekins' death was due to choking.

Before I went on leave I was aware from conversations with the HCA, SHCA and RGN that there was no evidence of choking, there was a DNACPR in place, the lady's

"Choking" risk assessment had shown she was not at risk of choking and she had never needed to be referred to the Speech and Language Team (SALT) and that she was frequently brought food by her family which she regularly ate in her room without incident. I was also aware that both emergency services had visited and had shown no concerns.

As a qualified nurse and Registered Manager of many years, I was also drawing on my past experience and had never been asked to conduct a formal investigation following a sudden death which had raised no concerns from either the ambulance or police services.

In line with CQC requirements, I submitted a Notification 16 (Death of a Resident) to CQC on 2nd October 2018 before I went on leave.

Following my return on 16th. October, (after I had been informed that the post mortem identified choking for the reason of death), I was asked to provide a personal statement to the Coroner's office along with all documentation relating to Mrs Mekins and formal statements from the care and nursing staff which I did.

I took the view, obviously mistaken in hindsight, that as CQC had been notified immediately and the Coroner was now carrying out a full investigation before the Inquest, that it would be inappropriate for me to conduct a separate investigation.

However, it became apparent at the end of November that further investigation was required and I submitted a Safeguarding Alert to Hartlepool Social Services on 3.12.2018.

I attended a Lessons Learned Meeting on 8th. January 2019, at which both Hartlepool's Safeguarding and Commissioning Teams, a representative from the CCG (NHS) and the Police were present.

It became apparent at this meeting that the family had been upset that they had initially been told by the Nurse on duty at the time that Mrs Mekins had died of a heart attack – which was obviously incorrect.

The CCG suggested we draft a Protocol for staff to follow after a death (sudden or otherwise) and we implemented this immediately following the Lessons Learned Meeting. The CCG also suggested that we draft a form where the home could document any concerns identified as risks associated with a resident's decisions and advice to mitigate those risks.

Again, we accepted this advice and produced a Health Concerns or Advice Sheet to identify to residents and/or families the possible consequences of their actions where concerns have been identified by care staff and unwise decisions may have been taken.

It was also apparent from my e-mails with your office that the Choking Risk Assessment used by Rossmere was not easily understood. We therefore liaised in depth with the

SALT team and, in consultation with them, produced a more user-friendly Choking Risk Assessment which is more easily understood by professionals and staff alike.

I can forward you copies of all these new documents if you wish and hope that the actions we have taken reassure you that our residents are not at risk of serious injury or death and that we have accepted and acted upon all advice from your office and from the Lessons Learned Meetings.

I attended a further Lessons Learned Meeting on 5th. March where the Safeguarding Investigation was closed with no further action required.

Please let me know if you require copies of any documents referred to in this response or any other information.

Yours faithfully,

[redacted]
Registered Manager