## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1 Jeremy Nixey, Chief Executive, Shaw Healthcare, 1 Links Court, Links Business Park, St Mellons, Cardiff CF3 0LT<br><br>2 Sir Andrew Dillon, Chief Executive, NICE, 10 Spring Gardens, London SW1A 2BU |
| 1 | **CORONER**<br><br>I am Karen Harrold, Assistant Coroner for the coroner area of West Sussex |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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<br>http //www legislation gov uk/ukpga/2009/25/schedule/5<br>http //www legislation gov uk/uksi/2013/1629/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 25 April 2017, the Senior Coroner, Penelope Schofield, commenced an investigation into the death of James William Francis aged 79 years old<br><br>The investigation concluded at the end of the inquest on 6 July 2018 I recorded a narrative conclusion as follows<br><br>James William Francis had a history of falls and balance issues arising from previous brain surgery and the insertion of a VP shunt The unwitnessed fall in his room on 9 April 2017 caused him to slip onto the floor either from his bed or a wheelchair This minor trauma was likely to have caused a shearing effect from movement of his brain within the cranium and led to stretching then rupture of one or more of the cortical veins He was sick three times some 10 hours later and again overnight Medical assistance was not sought His condition deteriorated the following morning and a call to a GP surgery was delayed by 4 hours Further sickness and other symptoms were not recognised until unconsciousness occurred and this led to an ambulance being called and admission to hospital where a CT scan confirmed a life threatening clot compressing the brain Surgery was not advised and despite attempts to reverse anticoagulation medication Mr Francis died on 11th April 2017 after palliative care Expert medical evidence confirms that earlier admission to hospital would not have altered the final outcome<br><br>The medical cause of death was recorded as<br><br>1a) Subdural Haematoma<br>1b) Brain Injury |

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| | 1c) Fall |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>Mr Francis was a 79 year old gentleman (DOB 8 July 1937) who lived at the Deerswood Lodge Care Home (the Home) in Crawley, West Sussex He was admitted to Deerswood Lodge from his daughter's home on 1 January 2016 His past medical history included a left occipital craniotomy and insertion of a VP shunt in 2001 following hydrocephalus, acoustic neuroma in 2005, and reported TIA in 2013 As a result, the Home noted he had periods of unsteadiness and balance difficulties resulting in a history of falls and he was prone to urine infections He was able to walk short distances with the assistance of a frame although he required a wheelchair for longer distances He was on anti-coagulation medication (Rivaroxaban)<br><br>Mr Francis had a previous fall at the Home on 1 March 2017 when he fell from his bed and bumped his head on the floor resulting in a slight bump and graze on the left side of his head An ambulance was called and he was taken to hospital but returned to the Home later the same day<br><br>He had another unwitnessed fall on Sunday 9 April 2017 I heard evidence from Jim's wife [redacted] when she visited the home at noon Jim was in the garden in the shade having a cup of tea He told her that he had slipped off the bed and landed on his bottom After discussion with the family during the inquest, it was suggested that because Jim's legs were weak he may very well have tried to lever himself up off the bed and his feet slipped from under him causing him to land on the floor on his bottom Jim told [redacted] that he had hit his head and had told the staff<br><br>By contrast, the night support worker confirmed in her statement that the sensor was activated in Jim's room at around 07 30 hours She found Jim on the floor and pressed the emergency button Jim did not wait for help and levered himself back onto the bed He was asked if he had hit his head and said no When asked how he had fallen to the floor, Jim told [redacted] that he was trying to sit on his wheelchair and the wheelchair ran out from behind him He was checked by a Team Leader for injuries but no bruises were noted and he indicated that he had not struck his head He remained responsive but was placed on 30 minute observations in line with standard practice in the Home<br><br>During the day, Mr Francis spent time in the garden and was visited by his family By 17 30 – 18 00 Mr Francis told a support worker that he had been sick in the bathroom By 19 00 – 19 30 he told the same care worker that he had been sick in bed and this happened again between 20 30 – 21 00 requiring a change of bedsheets He was therefore sick three times between 17 30 and 21 00 This was reported to more senior and experienced staff but no telephone advice was obtained<br><br>Night shift staff started around 22 00 and sometime after 22 00 a support worker heard Mr Francis vomiting so with the Team Leader they got Mr Francis out of bed and moved him into the lounge to prevent choking A few hours later there was a second episode of vomiting and some water was noted He was monitored until morning but he stayed upright in a chair in the lounge No call was made to a doctor or telephone advice obtained<br><br>By Monday morning Mr Francis condition was deteriorating and his day care worker could see Jim was very uncomfortable and trying to be sick He went straightaway to inform the senior nurse at about 08 40 to 08 45 She said to observed Jim until she could ring for a GP to attend This call was not made until four hours later at 11 40 after five separate reports from support staff including the fact Jim was slurring his speech Indeed, the day care worker discussed the need for a doctor to attend with Jim's wife at 11 00 such was the level of his concern The Team Leader says the call was at 10 40 but the manager reports the call was made at 11 41 Standard practice was for GP visits normally to occur in the afternoon<br><br>By 11 40 a support worker reported that Mr Francis was sick again and that this time it |

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| | was black but he wasn't sure if blood was present Other members of staff heard Mr Francis being sick and this was reported to the Team leader plus it was reported that he was burning up<br><br>By 15 20 the shift handover notes recorded that Mr Francis had become unresponsive so a 999 call was made The ambulance arrived at 15 26 and left with Mr Francis at 15 49 arriving at the East Surrey hospital at 16 05<br><br>A CT scan revealed a large right holohemispheric sub dural haematoma extending into the falx cerebri and tentorium cerebelli causing 1 6cm midline shift and there was evidence of uncal herniation on the right side Advice was taken from St George's Neurosurgical team and a registrar advised by telephone at 16 59 as follows<br><br>*Not an appropriate candidate for acute neurosurgical intervention Best supportive medical management Liaise with haematology - reverse rivaroxaban/ any coagulopathy (aiming INR<1 2, platelets >100), hold any blood thinning medications, ensure electrolytes are kept within normal range Neuro obs If survives acute presentation, repeat CT head in 2 weeks and rediscuss with us at point*<br><br>Mr Francis was treated in accordance with this advice but he sadly died on the 11 April 2017<br><br>Following his death no Post Mortem examination was carried out in light of the radiology report and doctor's referral of a death to the Coroner by [redacted] from East Surrey Hospital giving cause of death as -<br><br>1a) Subdural haematoma,<br>1b) Head injury |
| 5 | **CORONER'S CONCERNS**<br><br>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<br><br>The MATTERS OF CONCERN are as follows -<br><br>**1) Effectiveness of shift handover meetings**<br><br>I heard evidence from several staff members at different grades including two support workers responsible for Mr Francis's daily care, a senior support worker and a team leader that they were unaware of Mr Francis recent fall or the fact that 30 minute observations needed to be carried out In particular, both key support workers who knew Mr Francis best failed to carry out the 30 minute observations during the morning and afternoon shifts and on balance of probabilities it was likely that neither support worker was told either during the handover meeting or by the senior staff on duty that this was a requirement that day However, it certainly seems that both support workers observed Mr Francis on a regular basis throughout the day and took appropriate action to report his condition and any change to senior staff In another patient, this lack of handing on of vital information to key members of staff could be crucial<br><br>I was shown a shift handover form but this is basic and contains no additional guidance or method to highlight particular concerns or need for increased observations<br><br>**2) Monitoring & management checks**<br><br>Related to item 1 above, is the fact there seem to be a failure of appropriate management records and checks to ensure that if 30 minute observations were |

required that these were undertaken at regular intervals

3) **Delay in calling a GP or making a 111 call for advice & information given to GP when requesting Home visit**

I heard evidence that when Mr Francis was sick three times during the late afternoon and early evening of the day of his fall, no action was taken to seek out of hours medical advice

In addition, despite a significant deterioration in Mr Francis condition later in the day of his fall and more significantly the following morning and after five separate referrals by the day support worker to the team leader, there was a five hour delay in making a simple telephone call to request a GP visit Further, there does not appear to have been any thought given to making a call to NHS 111 for advice It was also unclear exactly what information was given to the GP surgery to stress the history and deterioration in Mr Francis condition

4) **Sufficiency of information given to paramedics & position of patient on the floor**

I heard evidence that the Ambulance crew received the call to attend Deerswood at 15 22 and arrived at 15 25 They reported that they found Mr Francis on the floor leaning up against the dining room chair and over to his right side They accepted that they were assertive but felt this was born from a frustration to find a time critical patient in such a position and staff were unable to answer basic questions about past medical history, allergies, mobility, communications for current medication It appeared to the crew that Mr Francis may have slipped out of the chair and his position may have compromised his breathing They knew the dispatch occurred at 15 15 and they arrived 15 27 so 12 minutes was available to the care home staff to prepare for their arrival and gather together all the required information Their joint recollection was that they found some paperwork including details of other residents and amongst those papers they found some details of Mr Francis medical history and current medication including balance issues, previous brain tumour in 2010 and that he was prescribed Riveraxaban plus there was a history of falls The crew were not concerned that Mr Francis was on the floor and felt that the recovery position would have been far better than the slumped position they found him in Nevertheless, they accepted that Mr Francis breathing was fine Again, it took some time to obtain all the details of the fall and sickness details

Finally, when leaving the building to get the stretcher trolley one of the paramedic crew heard care home staff arguing about the sickness details that had not been documented This evidence raises considerable concern regarding the adequacy of documenting key events in a patient's care such as a fall even if the patient indicates there was no acute trauma particularly when the patient is elderly and has a complicated past medical history

In addition, the paramedic suggested that other care homes have a key document that can be instantly handed over to them to speed up the handover procedure and ensure that clinical staff have a full history key information This is often called a Hospital Passport and uses simple traffic light alerts to highlight key information There was no evidence of this kind of simple document in this case

5) **Staff training**

I heard evidence from a number of staff members that they had received no training at all or it was some time (up to 3 years) since they had had any basic first aid training In addition, the paramedics indicated that when the care home staff were asked what their protocol and understanding was of a head injury with someone who was prescribed anticoagulant, it seemed the staff could not answer Nor could

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| | they spot the signs and symptoms of head injury even though this is basic first-aid<br><br>It would seem the care home staff had not considered placing Mr Francis on the floor into the recovery position until requested to do so by the 999 operator From reading the transcript it suggests that when the operator asked the staff to do this, efforts were made to comply and then ensure Mr Francis head was tilted to keep the airway clear and his breathing became a little less shallow Conversely, the ambulance crew were both very clear that their immediate concern on entering the room was the poor position of Jim in a seated/slumped position that may have compromised his airway<br><br>In addition one of the team leaders confirmed that she knew Mr Francis had a VP shunt in place but she was not aware of his past medical history or indeed what shunt did. This raises concerns about basic aspects of patient care and the adequacy of staff training<br><br>**6) Adequacy of NICE guidelines**<br><br>I heard expert evidence from Prof Mark Wilson, consultant neurosurgeon and prehospital care specialist at Imperial College NHS Trust He confirmed that what was more likely to have happened was that very minor trauma triggered the formation of the subdural haematoma His view was that the shearing force of landing on his bottom and missing the bed or wheelchair cause stretching and rupture of one of the cortical veins leading to the bleed In other words there was no direct head injury but instead there was movement of the brain within the cranium<br><br>When considering the care and treatment of Mr Francis at Deerswood Lodge from the time of the fall to the admission to hospital and whether the delay in seeking medical advice and attention caused or contributed to death, there was a discussion about relevant NICE guidelines concerning head injuries and falls The suggestion was that the existing guidelines may not sufficiently address the fact that this type of fall in the elderly also needs to be considered i e non-traumatic head injury leading to a shearing effect on the brain The suggestion was that this type of slow bleed may take significantly longer to manifest in terms of observable symptoms such as a change in alertness or persistent vomiting It certainly seems that the care home staff did not make the connection<br><br>As a result, this raises concerns as to whether this type of incident which must be frequent in the elderly is adequately taken into account in relevant NICE guidelines |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14 August 2019 I, the coroner, may extend the period<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons. |

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| | 1) The family of James William Francis,<br>2) [redacted] Director of Nursing & Safety, Shaw healthcare<br><br>I have also sent it to<br><br>1) [redacted] Consultant Neurosurgeon at Imperial College NHS Trust<br><br>I am also under a duty to send the Chief Coroner a copy of your response<br><br>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: 19 June 2019**<br><br>Karen Harrold<br>KarenHarrold<br>Assistant Coroner<br>West Sussex |