REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE TRURO CORONERS COURT

IN THE MATTER OF THE INQUEST TOUCHING THE DEATH OF EMILY DAISY SIMS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]**, Registered Manager, Antron Manor Care Home**
1	**CORONER** I am Guy Davies, Her Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.
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	**INVESTIGATION and INQUEST** On 16th November 2017 I commenced an investigation into the death of EMILY DAISY SIMS. The investigation concluded at the end of the inquest on 27th September 2019. The conclusion of the inquest was as follows: The four questions - who, when, where and how – can (therefore) were answered as follows;- Emily Daisy SIMS died on 1st November 2017 at Royal Cornwall Hospital Truro from trauma sustained as a consequence of the manner in which she was moved and manhandled out of bed, when in a frail condition. My conclusion as to the death was as follows;- Mrs Emily Sims died from a recognised complication of spiral fractures to her thighs sustained in an incident on Friday 27th October 2017 in which Mrs Sims was held by the ankles and swung out of bed by the night carer, applying torsion to the legs which caused the bilateral spiral femoral fractures. Whilst general frailty of health were likely to be co-factors, it is clear that the injury from the incident was the significant contributory factor which led to her death. The incident was contributed to by neglect, namely the manner in which she was moved and manhandled out of bed, when in a frail condition, by the night carer, which was more than likely to cause injury.

	The medical cause of death was established on the evidence as follows;- 1a Perforated duodenal ulcer in a frail, elderly female hospitalised with bilateral femoral fractures.
4	**CIRCUMSTANCES OF THE DEATH** At the time of her death 101-year-old Mrs Sims was a resident of the Antron Manor Care Home. There were no independent witnesses to the incident in which Mrs Sims sustained her injuries, bilateral spiral fractures to both femurs. Mrs Sims account (given to police before her death) was that she had been held by the ankles and swung out of bed by the healthcare worker. This caused her immediate and intense pain. The medical evidence established that this action would have the effect of applying torsion to the legs which caused the bilateral spiral femoral fractures. The stress of the fractures caused the ulcer which in turn caused the death of Mrs Sims. Evidence established that the night carer was or ought to have been aware of the risk of injury from moving and handling an elderly resident such as Mrs Sims in this manner. A review of the night carer's training record by the police revealed that the night carer had not undertaken moving and handling training since 2012. Care home staff gave evidence that they had not received training on the use equipment. Further that they had advised care home managers that Mrs Sims non-adjustable bed was, in their view, inappropriate for a resident in her frail condition. A review of Mrs Sims care plan by an occupational therapist revealed the following: 1) No new care plan had been completed to reflect Emily's changing needs. 2) There was no long-term plan to manage Emily's changing needs 3) There was no documentation of objectives in the care plan 4) Entries by staff on the care plan do not appear to have resulted in any changes to reflect Mrs Sims' changing needs and risks. 5) Mobilising equipment was incorrectly assembled. 6) Mrs Sims bed was non-adjustable and consideration should have been given to using an adjustable bed to diminish risks presented by the non-adjustable bed. The court heard evidence from a CQC report of January 2019 that there remained an issue of staff updating care plans with changing needs.

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) The lack of updating of care plans to reflect changing needs and how to manage changing needs** **2) The lack of updating of care plans to include reference to multi-disciplinary meetings or care needs meetings and decisions taken to manage changing needs** **3) The lack of the provision of appropriate equipment such as adjustable beds to address changing needs** **4) The lack of the provision, or access to, specialist advice from occupational therapists and physiotherapists to assist with measures to address changing needs** **5) The lack of appropriate training regarding the use of equipment and moving and handling**
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. I would be pleased to hear from you in relation to these concerns.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th December 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 the following Interested Persons: [redacted], the niece of Mrs Sims. 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	**9th October 2019** **Guy Davies, HM Assistant Coroner**