REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Managing Director, Borough Care Ltd, 9 Acorn Business Park, Heaton Lane, Stockport SK4 1AS

CORONER

I am Christopher Briggs, Assistant 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 16th May 2019 an inquest was opened into the death of Andrew Richard Hogg, who died at the Stepping Hill Hospital on 6th May 2019 aged 66 years. The investigation concluded at the end of the inquest which I heard on 22nd October 2019.

At the end of the inquest I recorded that Andrew Hogg died as a result of an accident, namely a fall he had on 3 May 2019 while at the Meadway Court Care Home, Meadway, Bramhall, Stockport SK7 1JZ as a result of which he suffered a head injury which led to a subdural haematoma from which he did not recover.

CIRCUMSTANCES OF THE DEATH

Andrew Hogg began to have difficulties coping and was referred to adult social services in 2017. Efforts were made to assist him in the community but increasingly he was unable to cope due to his underlying Parkinson's disease and possible dementia. He therefore moved into the Meadway Court Care Home on 20 April 2018 where he was resident until his death.

Andrew had a history of falls and mobilised with a stick, although sometimes without it which increased his risk of falling. I heard evidence that staff were aware of his risk of falling but it was not clear what if any falls assessment had been undertaken. I was told that consideration was given to placing a falls mat beside Andrew's bed in December 2018 but he declined this thinking it would be a trip hazard.

Andrew then had a series of falls as follows:-

16.1.19 fall in lounge – cut forehead – paramedics attended

23.2.19 – unwitnessed fall in bedroom – cut on elbow

14.3.19 – unwitnessed fall in lounge – paramedics attended

30.3.19 – unwitnessed fall in bedroom

24.4.19 – witnessed fall in lounge area – cut to forehead - Paramedics attended

25.4.19 – fall in downstairs lounge – bang to head and lump on shoulder paramedics contacted however out of hours GP attended

26.4.19 – unwitnessed fall in bedroom - telephone advice from out of hours GP.

On 1.5.19 the lump on the shoulder and bruising were more noticeable and Andrew was taken to hospital where a fractured clavicle was diagnosed. This was treated with support and he was discharged back to the Home on 2.5.19.

Upon his return staff recognised Andrew was at high risk of falls and it was planned that Andrew should not walk alone and mobilization should be by wheelchair with one carer at all times.

On 3 May 2019 Andrew was found on the floor of his room. An ambulance was called and he was admitted to Stepping Hill Hospital where CT scan revealed a large subdural haematoma. Following discussion with the neurosurgical team in Salford Royal Hospital it was concluded that Andrew would be unlikely to survive any operative intervention and palliative care was given until his death on 6 May 2019.

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. –

I heard evidence of the sequence of falls which I have recounted above. While there may have been a falls assessment when Andrew first became resident at the home, there was no evidence before me of the nature and extent of that assessment. More particularly there was no evidence of any steps taken to review or reassess the falls risk following the falls Andrew had commencing in January 2019. There were some 7 falls before his final fall and it is a matter of concern that while each seems to have been dealt with reactively in that relevant assistance was sought, there were no steps considered to address what clearly was an escalating risk.

In evidence I heard from [redacted] who was the manager of the home (although I accept he was only recently in post). [redacted] having given evidence as to the facts above accepted that insufficient measures were taken to address the risks which were evident. In particular he identified that:-

1. Not all the relevant paperwork was completed following the falls
2. There could have been engagement with other services such as the local falls clinic
3. Consideration should have been given to using available equipment such as a sensor mat and "silent minder"
4. Relevant information should have been updated onto the patient's electronic record.

While I welcome his insightful comments I remain concerned that

1. There was no adequate falls assessment policy
2. There was no obvious escalation pathway following the sequential falls Andrew had
3. There was no internal investigation into any of the falls which occurred
4. There was no consideration of steps which could have been taken to reduce the risk, whether by way of equipment or increased or more direct carer supervision.

It seems to me that each incident was dealt with reactively and individually with no proactive consideration given steps which could be taken to reduce or ameliorate the risk of falling which quite obviously was increasing.

While it cannot be said that had such steps been taken Andrew would not have fallen when he did, I do think that the risk of that happening would have been substantially reduced.

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 22nd January 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted], Andrew's brother.

I have sent a copy of my report to the Manager of the Meadway Court Care Home.

I have sent a copy of my report to Stockport MBC Social Services Department.

I have sent a copy of my report to the Care Quality Commission, 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: 27th November 2019

Signature:

Christopher Briggs HM Assistant Coroner, Manchester South.