IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Iris Irene SKINNER
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** • Dr Pete Calvely, Chief Executive Officer Barchester Healthcare 3rd Floor The Aspect 12 Finsbury Square London EC2A 1AS
2	**CORONER** Miss Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** The inquest into the death of **Mrs Skinner** was opened on 31 October 2018. It was resumed on 26 November 2019 and the conclusion was handed down on 27 November 2019. The medical cause of Iris Skinner's death was: 1a. Intra-cranial haemorrhage 1b.Fall 2. Mixed Dementia (Vascular and Alzheimer's Dementia) The inquest concluded with a short-form conclusion of 'Accident'.

5	**CIRCUMSTANCES OF THE DEATH** Mrs Skinner was a resident at Windmill Manor Care Home in Oxted which is run by Barchester Healthcare. On 18 October 2018 she lost her balance and fell over whilst at the care home. She was taken to East Surrey Hospital the following day on 19 October 2018, where she was found to have sustained a fatal head injury. She died at East Surrey Hospital on 23 October 2018. At the inquest the Coroner found that there were a number of omissions in relation to the management of Mrs Skinner following the fall: - There was an omission to carry out sufficiently frequent neurological observation, as well as a complete omission to carry out any observations from midnight to 7am on 18 October 2018, in breach of the Barchester Healthcare head injury policy. - The observations which were carried out were not sufficiently comprehensive in that there was an omission to record both Mrs Skinner's temperature and respiratory rate on all but one occasion, again in breach of the Barchester Healthcare head injury policy. - As a result of those omissions it has not been possible to establish precisely when Mrs Skinner's condition began to deteriorate and whether an admission to hospital would have been indicated at some point during the course of the night. - At 9.30am on the morning of 19 October 2018 Mrs Skinner was observed to have vomited and to be unresponsive. Thereafter there was a significant delay, the reasons for which remain unknown, in the calling of an ambulance, which was not called until 11.22am, again in breach of the Barchester Healthcare head injury policy. The omissions identified in Mrs Skinner's care did not cause or contribute to her death. However, they remain a matter of serious concern, the reoccurrence of which would present a risk to the lives of current residents.

6	**CORONER'S CONCERNS** The Coroner's concerns are as follows: The Barchester Healthcare Head Injury Policy is a comprehensive policy which sets out the appropriate response to implement when a resident is suspected of having sustained a head injury. The court heard evidence from Jayne Holloway, a Regional Director for Barchester Healthcare who informed the court that since Mrs Skinner's death all trained permanent staff at the home have been asked to confirm that they have read and are familiar with the Head Injury policy. However, the court also heard evidence that a significant number of agency staff are employed by the home and that the same process has not been followed in respect of agency staff. The **MATTER OF CONCERN** is: - Agency staff employed by Windmill Manor Care Home in Oxted, and potentially more broadly across the Barchester Healthcare group, may be unfamiliar with the Barchester Healthcare Head Injury Policy.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Iris Skinner's family 3. Care Quality Commission
10	**Signed:**  **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 17th day of December 2019**