	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Oak Court House, Oaks Crescent, Wolverhampton WV3 9SA 2. Wolverhampton City Council
1	**CORONER** I am Mrs Joanne Lees, Area Coroner, The Black Country Jurisdiction
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 7/1/20 I commenced an investigation into the death of Edna May Davenport who died on the 12th December 2019. The investigation concluded at the end of an inquest on the 9th March 2020. The inquest concluded with a short narrative conclusion as follows: *'The deceased died from head injuries most likely sustained during an unwitnessed assault on a background of old age and frailty'.* The Medical Cause of Death was: 1a chronic subdural hygroma/haematoma with mass effect 1b traumatic 2 IHD, CVA, Diabetes, old age and frail(ty)
4	**CIRCUMSTANCES OF THE DEATH** i) On 2nd October 2019 the deceased was admitted to Oak Court House residential care home. She was admitted from a previous care home where she had been resident since 4/9/19 following a stroke. ii) The deceased required assistance from 2 carers at all times for personal care, dressing and transferring as she was mainly bed bound and immobile and paralysed down her left-hand side; iii) The deceased had a previous medical history of cerebrovascular disease, previous stroke, IHD and CKD; iv) On the 20/11/19 during the early hours care home staff found another resident sat in a chair in the room of the deceased and the deceased with a red mark to her eye and a scratch to her right arm; v) The deceased was able to report to her daughter that she had been attacked in her bed by this other resident who had got into bed with her without any clothes on and hit her to the face; vi) By the following morning the injury had developed into a bruise on her cheekbone; vii) At the time of the incident there was no buzzer or alarm in the room of the deceased as it had been removed/immobilised due to a concern that she may self-harm;

	viii) The deceased was seen by the district nurse the same day but an ambulance was not called until the 29th November when the deceased became drowsy and unresponsive; ix) On admission to hospital a CT scan revealed a bilateral subdural hygroma/haematoma with mass effect. Sadly, she was unable to be treated surgically due to multiple co morbidities and she deteriorated and passed away in hospital on 12/12/19; x) A post mortem examination revealed traumatic injuries leading directly to her death.
5	**CORONER'S CONCERNS** During 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) During the course of the inquest, I heard evidence that buzzer/alarm in the deceased room had been removed/disabled due to a previous incident where the deceased had attempted to place the cord around her neck. The family were told that as a result, observations of the deceased had been increased to every 15 minutes day and night. There was no evidence of this in any written records or care plan and no evidence of alternative arrangements in her care plan being made to enable the deceased to call for assistance from her room should it be needed given her disabilities; (2) I heard evidence that the deceased was subject to hourly observations but that these observations were not recorded as to when they actually took place or what was observed. Therefore, it was not possible to ascertain how long the other resident had been in the room with the deceased or how long the assault went on for; (3) I also heard in evidence that the deceased preferred to have her bedroom door left open but this did not form part of her care plan and there was no evidence as to when the door was in fact left open, or when it was closed, or indeed whether the door was open when the other resident was found in the deceased's room; (4) I heard evidence during the inquest that the other resident suspected to have been the assailant was a new referral to the home and that there was a lack of information on her admission. The evidence at inquest was that staff were unaware that she was aggressive as a result of her vascular dementia. There was some evidence identified during the police investigation that this resident had attacked a member of staff shortly after her admission and that she had been inappropriately placed at Oak Court house. There was no evidence that any risk assessment had been undertaken after that resident's admission or after the first alleged attack to address the risk of violence that the resident posed to others by virtue of the extent of her dementia; (5) I heard evidence that there were obvious signs of an injury to Edna's head in the form of the injury to her eye which resulted in bruising and swelling. There was also evidence that the deceased had been punched to the head. The District Nurse recorded that Edna had had a headache and the deceased had complained to her daughter about suffering with a headache shortly after the

	assault. Despite this, no neuro observations were undertaken and there was no change to the frequency of Edna's observations; (6) The evidence was that staff had been informed by the Manager to continue carrying out hourly checks and to call an ambulance if there was any change but there was no evidence of this in any of the deceased's records or daily notes; (7) No further checks were carried out by the home manager after this time and it appeared that evidence of the deceased becoming unwell and suffering with episodes of drowsiness were not recorded or indeed reported by staff caring for her. I am concerned that Oak Court does not have a clear policy in place to manage head injuries; (8) The deceased was an elderly lady who had suffered a head injury and was known to be anti-coagulant medication, yet no medical review was sought until an ambulance was called on 29/11/19 when the deceased became unresponsive. A concern was raised by hospital staff on her admission and a safe guarding referral was made. (9) The Coroner noted the CQC inspection report following a visit undertaken in July 2019.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action. Oak Court may wish to review their internal policies and procedures following Edna Davenport's death and consider any further action. The Coroner would invite them to consider the following; • Record keeping; • Head injury management; • Care plan updating; • Alert systems for residents with disabilities; • Quality of information in new referrals supporting decision making; • Safety Risk assessments for patients vulnerable due to disability; • Staff training. The City Council may wish to review management at the home. The CQC may wish to consider a further visit.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1/6/20. 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] daughter of the deceased.

	I have also sent a copy of my report to the CQC. 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	 **Mrs Joanne M. Lees** **Area Coroner** **The Black Country Jurisdiction** **3/4/20**