	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Hart Care Limited** **Hart Care Nursing and Residential Home** **Ravenscroft** **Old Crapstone Road** **Yelverton** **Devon PL20 6BT**
1	**CORONER** I am Stephen Hugh Glossop Covell, Assistant Coroner for the coroner area of Plymouth Torbay and South Devon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 13 March 2020 Mr Ian Arrow, the senior coroner for Plymouth, South Devon and Torbay commenced an investigation into the death of Clara Ellen Freeman aged 87. The investigation concluded at the end of the inquest on 19 February 2021.The conclusion of the inquest was the narrative conclusion; Clara Ellen Freeman died at 02.37 on 6 March 2020 on Monkswell Ward, Derriford Hospital, Plymouth. The Deceased suffered an unwitnessed fall at Hart Care Nursing and Residential Home at around 21.30 on 3 March 2020. The Deceased was discovered by care staff but developed medical complications as a consequence of a period of approximately 4 hours being kept on the floor of her room immobilised before an ambulance conveyed her to hospital. The Deceased eventually succumbed in hospital to the medical complications. The cause of death was; I a Acute Kidney Injury I b Rhabdomyolysis and Sepsis of Unknown Origin II Heart Failure, Atrial Fibrillation, Frailty and Hypertension
4	**CIRCUMSTANCES OF THE DEATH** The Deceased suffered an unwitnessed fall at Hart Care Nursing and Residential Home and was found on the floor of her room on her left side, conscious, but in pain. The ambulance service was contacted at 21:48, which advised that there was heavy demand for the ambulance services at that time and the average waiting time was 2 hours. Advice was given not to move the Deceased and to dial 999 if the Deceased's condition worsened. An ambulance arrived over 3.5 hours later at 01.23 during which time the Deceased was kept immobile on the floor. The care and nursing staff at the care home made 999 calls at 23.04 and 00.04 to ask when the ambulance would arrive and advising that the Deceased was in intense pain and (at 23.04) that the Deceased's temperature and pulse had risen. Observations by the nursing staff also recorded that the Deceased's oxygen saturations reduced during the wait and that latterly the Deceased's colour appeared cyanosed. This information was not handed over in the telephone calls nor was any concern raised about the risk to the Deceased being kept immobile over such

	a long period of time. The information would have been important to the call handler to assess whether the Deceased's condition was deteriorating or whether to refer the matter to a clinical adviser and potentially reassess the category of response.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Evidence was heard regarding the level of proficiency of the care and nursing staff in dealing with the care of the Deceased after her fall and the interaction of staff with the ambulance service control centre call handlers, particularly in the passing of relevant information and any changes in the Deceased's condition. It is requested that the training for care and nursing staff be reviewed to consider; a) Effective interaction with the ambulance service and other medical service providers after an accident or medical emergency b) Accurate recording of medical information including vital signs c) Awareness of the risks of medical complications following falls and long lies.

6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 21 May 2021. 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] Southwest Ambulance Service NHS Trust 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	Dated 26th March 2021 Signature [signature]