ANDREW HETHERINGTON
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Baedling Manor Care Home, Alcyone Healthcare
1	**CORONER** I am Andrew Hetherington, Senior Coroner for North Northumberland and Acting Senior Coroner for South Northumberland.
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://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 1st October 2020 I opened the inquest into the death of Margaret Elizabeth GREENACRE, held a pre-inquest review hearing on 3rd November 2020 and heard the inquest on 10 February 2021. Dr [redacted] found the cause of death to be: 1a Aspiration Pneumonia 1b Immobility 1c Traumatic Haematoma of Right Leg 2 Frailty of Old Age The conclusion of the inquest was: Box 3: On 30 August 2020 the deceased suffered an unwitnessed fall at Baedling Manor Residential Care Home. She was taken to Northumbria Specialist Emergency Care Hospital and was found to have a traumatic haematoma to her right leg. She was transferred to Wansbeck General Hospital for continued monitoring. A fracture and intracranial injury had been excluded. She was initially prescribed antibiotics, but cultures did not identify an infection and were discontinued. The haematoma developed into a wound that required regular dressing. She continued to deteriorate and was receiving palliative care until her death on 18 September 2020 within Wansbeck General Hospital. Box 4: Accident

4	**CIRCUMSTANCES OF THE DEATH** Margaret Elizabeth Greenacre known as Betty was a resident at Baedling Manor Care Home having been admitted on 7th February 2019. I heard that on 30th August 2020 Betty suffered an unwitnessed fall and was found in the doorway of her bathroom fully clothed with her underwear in place. Betty was taken to Northumbria Specialist Emergency Care Hospital and was found to have significant soft tissue damage to her lower right leg, but imaging excluded a fracture or intracranial injury. Betty was transferred to Wansbeck General Hospital. The wound developed and required regular dressing. Betty deteriorated and died within Wansbeck General Hospital on 18th September 2020.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – 1. On 4th September 2020 the Care Quality Commission received information from a whistle-blower regarding information of a safeguarding nature in that a service user had fallen and was taken to hospital having sustained a leg and head injury. This was confirmed to be Betty who died on 18th September 2020. Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 provides that registered persons must notify the Care Quality Commission, without delay. The Care Quality Commission contacted Baedling Manor Care Home on 8th September 2020. Statutory notification was received at the Care Quality Commission on 12 September 2020. It is of concern to me that the Care Quality Commission were notified of concerns by a whistle-blower and, that statutory notification was not made until 12 days after the incident. It came to light during the inquest that an incident also arose in July 2020 but no reports have been submitted to date. It is of concern to me that matters are not being reported or are being notified late which may prevent incidents being investigated. 2. I have concerns with regard to the standard of record keeping at Baedling Manor Care Home, I am concerned that the care notes did not present an accurate picture of a resident and did not reflect what a resident was like and therefore what their needs were. It was accepted in evidence that the record keeping was very poor, the care plans were not changed or updated. In fact, upon the appointment of a new home manager, every resident's care plan has been reviewed and updated. The information provided in the care plan contradicted the information provided in evidence and it appears staff may have had difficulty understanding Betty's care needs for lifting.
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 14th April 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 • Care Quality Commission • Northumbria Healthcare Trust • Local Safeguarding Board I have also sent it to [redacted] (son) and [redacted] (daughter) 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.
9	17th February 2021 Signed: A. P. Hetherington