	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Registered Manager,** **Rossendale Nursing Home,** **96, Woodlands Rd** **Ansdell,** **Lytham St. Annes**
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
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 04/06/2020 00:00:00 I commenced an investigation into the death of Dereck John CHAPMAN, known to his Family as John. I concluded an inquest on 26th August 2020. The medical cause of John's death was as follows: **1 a Acute cardio-respiratory failure, due to** **1 b Lobar pneumonia and coronary heart disease** **2 Osteoparotic fracture of left neck of femur (operated on 16th January)** The conclusion to the inquest was a narrative conclusion as follows: **John Chapman died as a result of pneumonia and heart disease at a time when he was recuperating in hospital following a surgical repair of a fractured neck of femur received during a recent fall at the nursing home where he resided.**
4	**CIRCUMSTANCES OF THE DEATH** The circumstances were summarised In box 3 of the Record of Inquest where I determined as follows; **John Chapman was known to have a medical history which included chronic obstructive pulmonary disease, atrial fibrillation and osteoarthritis. He had previously been diagnosed with dementia and had reduced capacity. He had recently been prone to falling and was mobilising less frequently. He was prone to putting himself on the floor. On 13/01/20 at 10.10 pm he was witnessed by staff to fall in the dining area at the nursing home where he resided. He was observed overnight. At 3.00 am on 14th January 2020 a motion sensor indicated John had left his bed and he was found on the floor by his bed. His presentation was not concerning until around 8.00 am later that morning when he was observed to be in pain. Later that morning an ambulance was contacted and he was transferred to hospital arriving at around 4.00 pm where investigations revealed a left neck of femur fracture which was surgically repaired on 16/01/2020. The procedure was uneventful following which he remained settled. On 17/01/2020 he was noted to have a reduced level of consciousness. Over subsequent days his condition deteriorated. By 24/01/2020 after discussions with his family John began to receive end of life care and was kept comfortable until he died on the 03/02/2020. A subsequent post mortem examination confirmed that John died from the combined effects of heart disease and pneumonia.**

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. – (1) **Response of staff at the nursing home:** John had previously been diagnosed with dementia. He was at high risk of falling. His cognitive difficulties were such that he could not fully understand questions put to him, and nor could he reliably describe his symptoms. On 13th January 2020 he was seen to fall and as he did so his crown made contact with a wheelchair. The contact was felt to be minor. Some five hours later he was found face down on the floor by his bed. He was not felt to be in pain and was returned to his bed until approximately 8am on 14th January 2020 which resulted in a transfer to hospital later that day. Having considered all of the evidence I felt that the response from nursing home staff was insufficient and did not appear to have appropriately taken into account his dementia, that he may be experiencing symptoms but was unable to reliably communicate this to staff. As it transpired he did undergo a CT head scan which confirmed he had not suffered a significant head injury but this cannot have been obvious to staff at the relevant time. I did determine that the response from the nursing home staff did not contribute to the eventual outcome for John but this may not be the case in the future. I am concerned that such an insufficient response raises a risk of future deaths. (2) **The quality of record keeping:** during the course of the coronial investigation the court was provided with nursing home records and documentation. The quality of that documentation was unimpressive. Consideration of that documentation did not provide an accurate or reliable narrative as regards John's care or the events that had taken place during the latter stages of his residence at the nursing home. By way of illustration the Nursing Home Manager had provided a document to the court which made reference to John having been found on the floor out by his bed at approximately 5.30am on the 14th January 2020 but the source of that information could not be identified, There was no evidence to support this within the documentation provided and when asked in evidence the Manager could no longer recall from where / whom she had learned of that information and therefore the court felt unable to place any weight upon it. Nursing Home documentation needs to be accurate, detailed and reliable. If a potentially significant event occurs in relation to a patient it needs to be recorded so that other staff are aware of it and can take it into account. An accurate and reliable account of events is essential in order to ensure that in the event of an investigation / review of a significant incident or fatality such investigation needs to have access to the relevant information in order to ensure lessons are learnt and appropriately reflected upon. When this is not possible it poses a risk that other deaths may arise in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 **23rd October 2020**. 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:

	The Family of John Chapman; I have also sent it 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.
9	27/08/2020 Signature__  Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**