Care Home Fatality Investigation

Judy Hulland

EHS Team Leader –Commercial

South Kesteven District Council

Incident location

Orders of St Johns Care Trust

Whitefriars, Stamford

Dorothy Spicer

Dorothy Spicer

- Resident since 2007
- Regularly visited by 2 daughters and other family members
- Had dementia, osteo-arthritis and was incontinent
- Independently mobile but walked with aid of walking stick
- Was NOT known to “wander”
- Required personal care eg bathing, putting to bed
- Could feed herself but required supervision
- Enjoyed watching TV, singing and music, company
- Had a wicked sense of humour
- Liked by staff

Time line

25 Nov 2009	14:00	Fire Training sessions in Poppy Lounge
	20:30	Mrs Spicer last seen in Poppy Lounge
26 Nov 2009	05:00	Mrs Spicer's bed discovered unslept in
	05:20	Mrs Spicer discovered in garden, taken inside and Out of Hours Dr called
	06:40	Morning shift arrived
	06:41	Ambulance called
	06:43	Ambulance arrived, taken to Peterborough hospital, hypothermia confirmed. Police and Safeguarding adult informed. Investigations began
21 Jan 2010		Mrs Spicer dies
25 Jan 2010		EH informed of incident

What happened next

EH commenced investigation

- Checked with HSE re enforcing authority
- Visited premises.
  - Most evidence required was with police
- Established new controls were in place to prevent reoccurrence

Lincs Police continued to lead on investigation

- Considered prosecution for:
  - Corporate Manslaughter
  - Negligence/ill treatment under Mental Health Capacity Act 2005
  - CPS rejected case in October 2010.
  - Reviewed and rejected February 2011

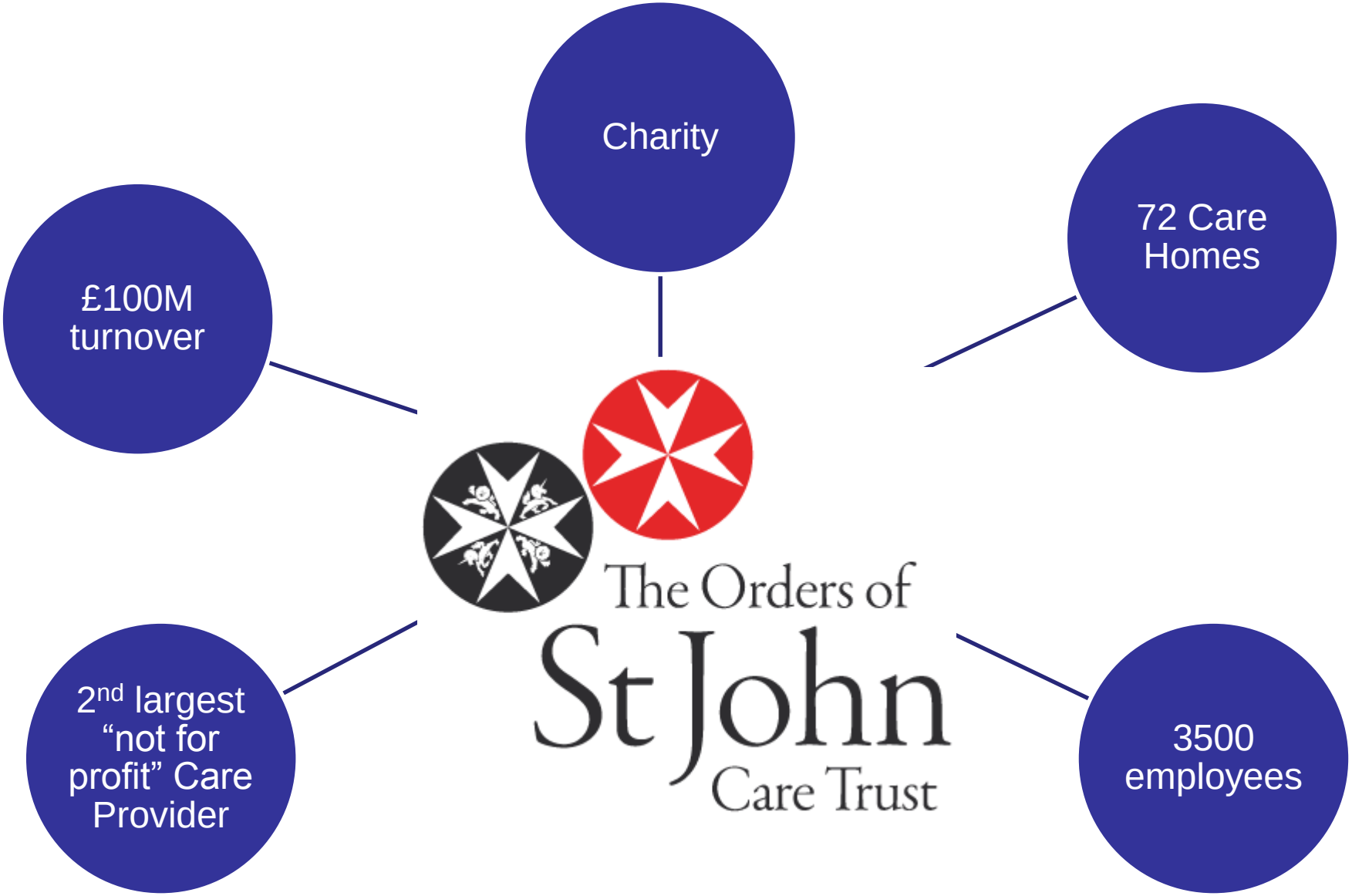
What happened next (cont)

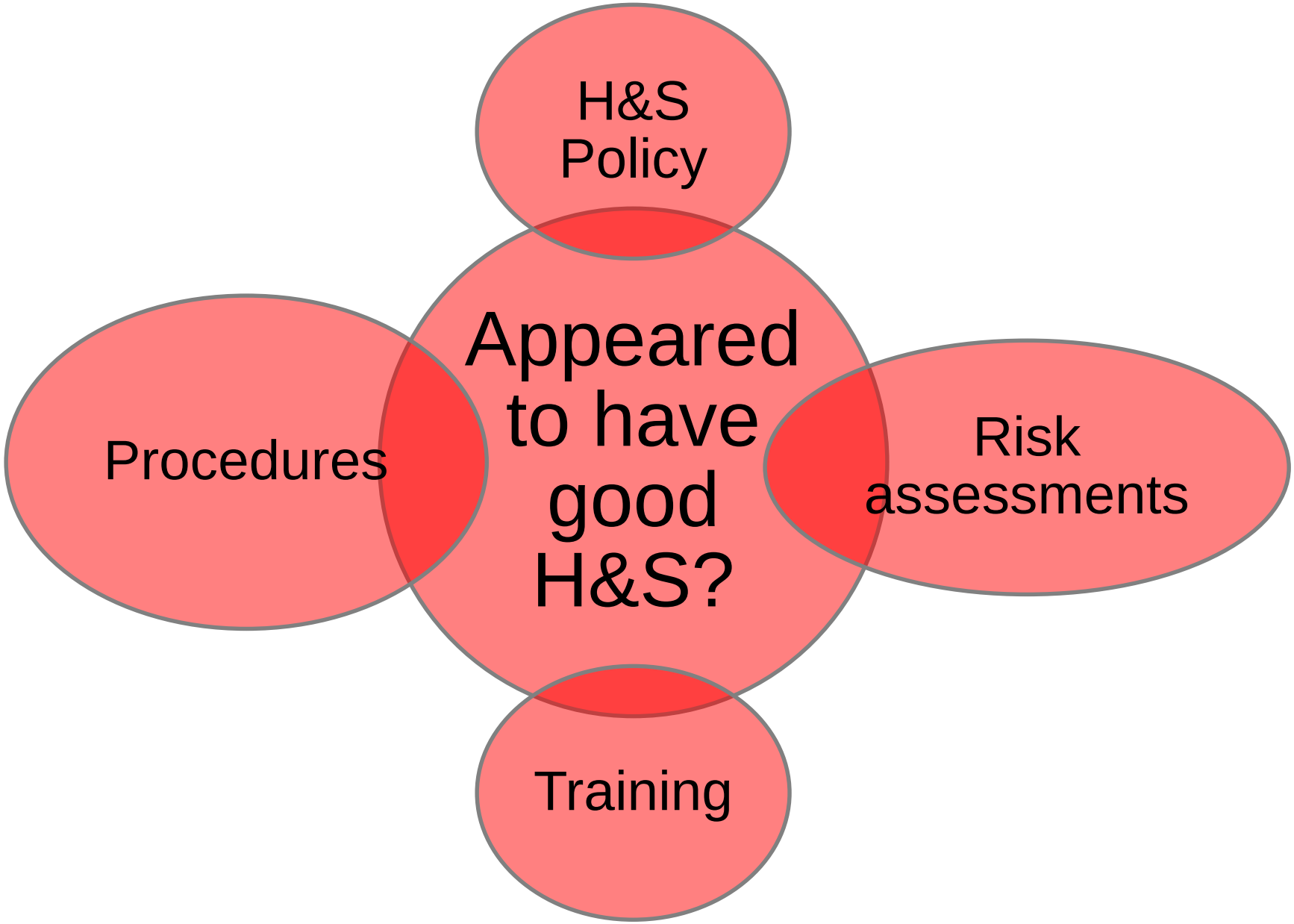
- EH continued to meet with Lincs Police and Safeguarding Adults
- Agreed that following Coroners inquest case would be transferred to EH
- Evidence transferred to EH April 2012
- Evidence reviewed
- Report to Legal in November 2012

Coroners Court

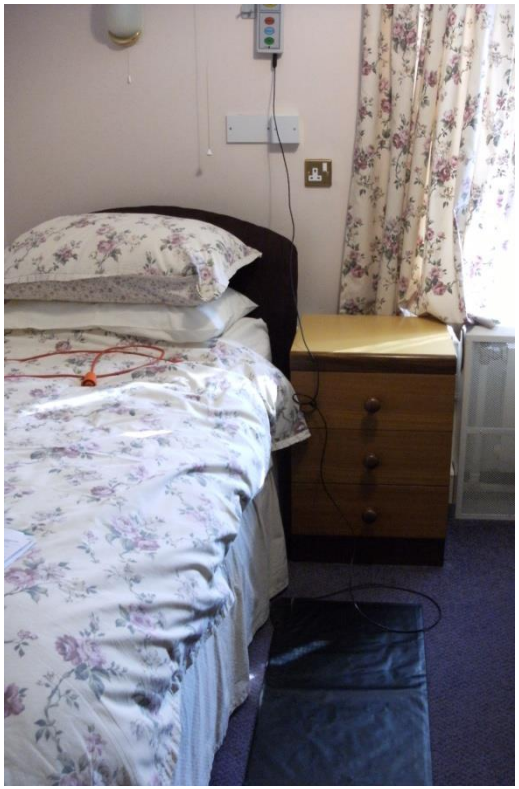
- **Pre-inquest hearing in October 2011**
  - Request from family legal team for Jury
- **Coroners Inquest held in February 2012 for 4 days**
  - **Narrative verdict**
    - Cause of death was broncho-pneumonia due to decreased mobility following an episode of hypothermia on 25/26 November 2009 with dementia as a contributory factor

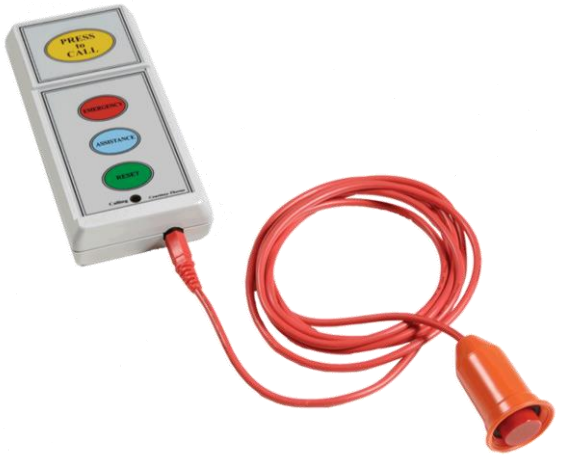
Background information


Charity
72 Care Homes
£100M turnover
The Orders of St John Care Trust
2nd largest "not for profit" Care Provider
3500 employees

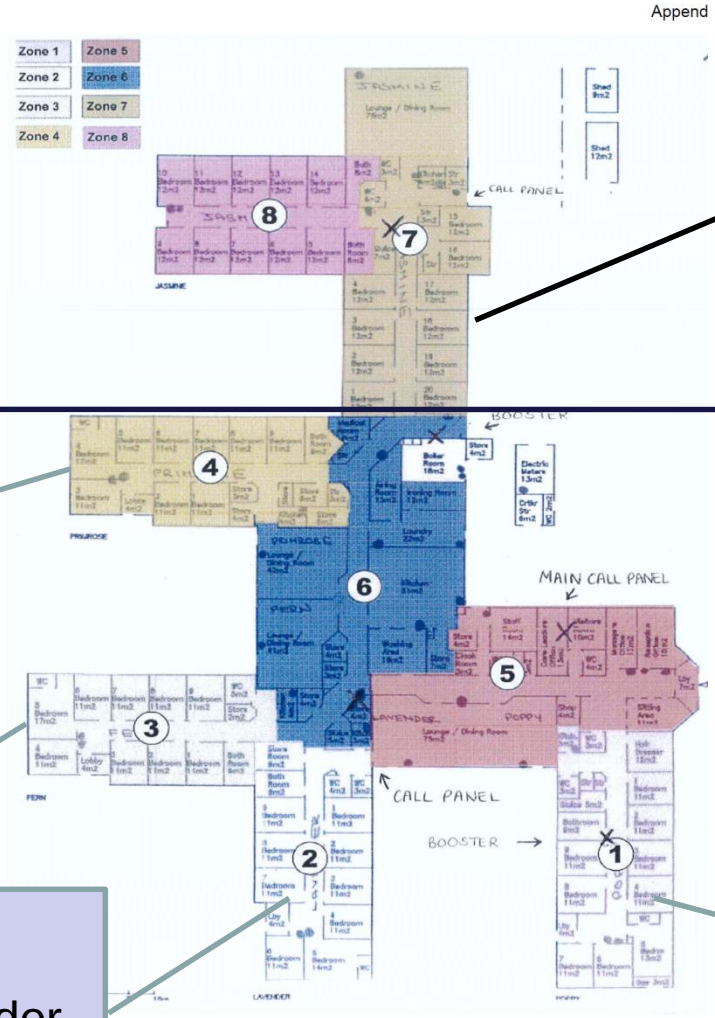

H&S Policy
Procedures
Appeared to have good H&S?
Risk assessments
Training

Courtney-Thorne
call systems





Whitefriars' staffing on night shift



JASMINE UNIT
High Dependency
Dementia unit
20 beds
2 night carers

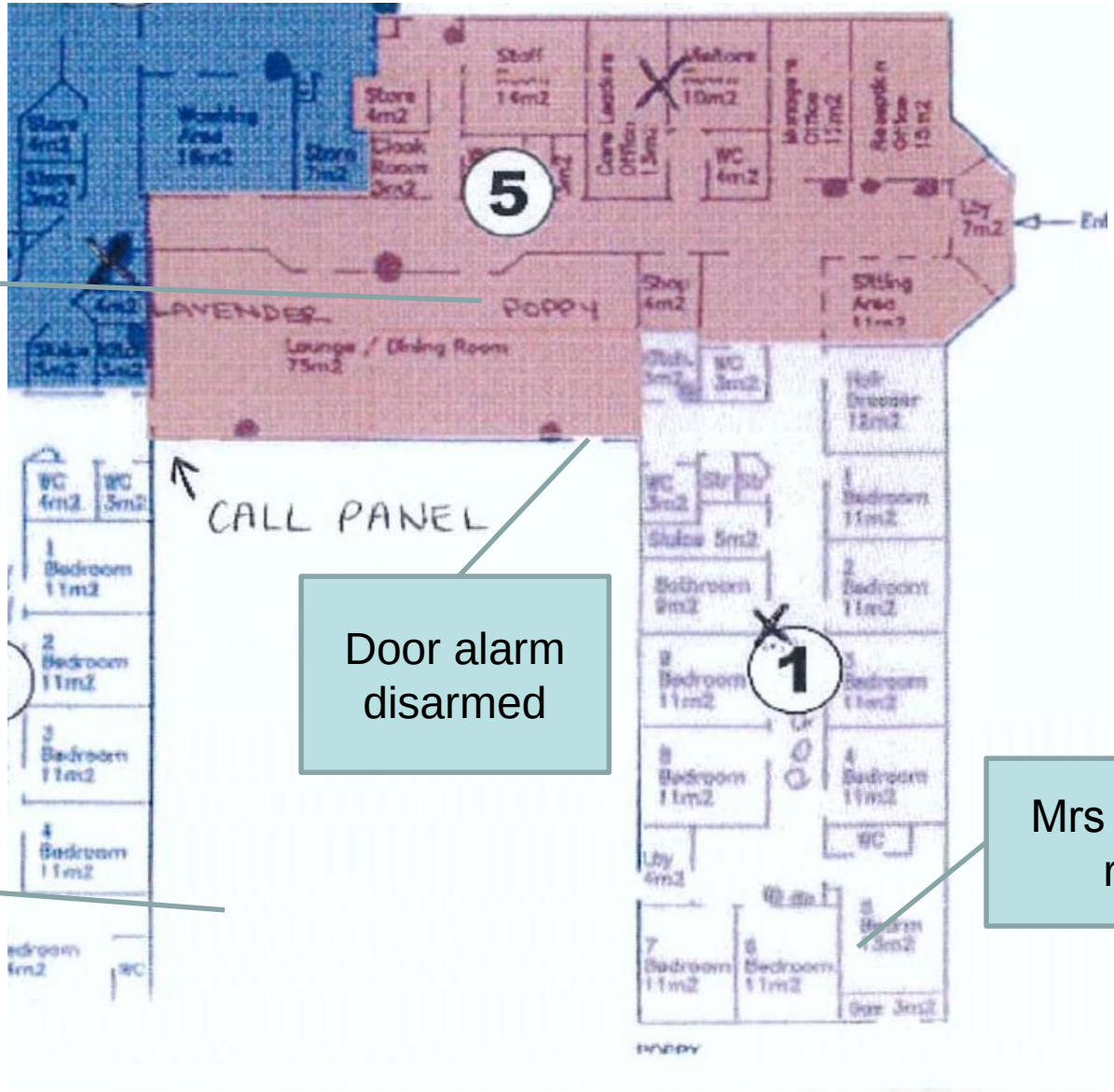
Primrose

Fern

Lavender

Poppy

4 other units each with 9 beds.
2 night carers


Fire training held in Poppy Lounge
Door alarm disarmed
Mrs Spicer found here
Mrs Spicer's room
5
1
POPPY
LAVENDER
Lounge / Dining Room
CALL PANEL

What went wrong

- **Staff under stress on pm shift**
  - 1 staff member down on afternoon shift because of fire training
  - Staff under pressure as several incidents with residents
  - **Residents disorientated because residents lounge used for training**
  - Staff disciplined mid shift by Deputy Care Manager for having tea break together –claimed hadn't had break all pm.
  - Afternoon staff refused to stay for handover
  - Deputy Care Manager got upset

What went wrong

- **Night shift arrangements**
  - 1 key holder and 3 other staff
  - 2 staff assigned to Jasmine
  - 2 staff covering remaining 36 beds
  - On this night one staff member removed for approximately 2 hours for drug training
  - 1 person left looking after 36 people at bedtime

What went wrong

- **Staff competency/capabality**
  - **Night shift keyholder**
    - Determined by most experienced, not most competent
    - Did not call ambulance immediately
  - **Deputy Care Manager**
    - Had handed notice in.
    - Professional attitude but acknowledged that not suited to the role.
    - Did not like disciplining staff
  - **Care Home Manager**
    - Failed to address issues raised by staff

What went wrong

- **Handovers**

– No handover occurred between afternoon and night shift. Some paperwork completed, but not all. No verbal communication

– Care leader carrying out handover had been in training so not aware of all issues

– Staff wanted to go home

– Handover sheets identified as incomplete several times previously

– Handover quality raised in a staff meeting November 2009 prior to incident

Failings in alarm system/procedures

- Personal staff pagers missing/broken – 1 available for shift
- Alarms would be going off frequently and staff would have to refer to control panels
- 2 control panels situated in Jasmine and office corridor
- Computer needed to be standalone, but was used for all office work

Failings in alarm system/procedures

- Door alarms could be overridden
- Some doors would “pop open”
- Staff knew these doors and would just reset alarm without checking
- Poppy Lounge door alarm shown to be deactivated from 24 to 26 November
- Daily checks probably not undertaken correctly

What went wrong

- **Missing resident procedure**

– Procedure to identify if residents missing after door alarm set off not followed

– Door alarm set off about 9.00pm on 25/11/15
  - Carer allegedly checked garden
  - Found no-one and assumed no-one outside
  - Did not tell anyone

What went wrong

- **Bedtime**

– Aim was for residents to be put to bed by afternoon shift – residents often in bed by 7.30pm

– Shift changeover 9:30pm

– Mrs Spicer's normal bed time was around 9:00 to 10:00pm

– No method of checking residents had been put to bed

– Night staff hourly check sheets were for security of home rather than resident care

Offence

- **HASWA Section 33**
  - Failure to discharge a duty under Section3(1) of HASWA
  - Section3(1)
    - It shall be the duty of every employer to control his undertaking in such a way so far as is reasonably practicable, that persons not in his employment are thereby exposed to risks to their health and safety

Other contraventions considered

- **Management of H&S at Work Regs 1999**
  - Reg 3(1) Risk assessments
  - Reg 5(1) Health and safety arrangements
  - Reg13(1) Capabilities of employees
  - Reg 13(2) Training
- **RIDDOR**
  - Failure to report an incident (MoP directly to hospital)

Date	Court	Action
April 2013	Magistrates	No plea entered
May 2013	Magistrates	No plea Committed to Crown Court
September 2013	Crown	No plea entered
December 2013	Crown	Court dated moved following intention to plead guilty
January 2014	Crown	Guilty plea and sentenced

Fine **£140,000**

Costs **£65,000**

Defence challenges

- **Fault of an individual (Sections 7 & 36)**
  - Some individual staff performed well below the expected level

  BUT

  - Some management systems were inadequate
  - Some management systems not being followed
  - Management did not always address issues when staff alerted them to failings

Defence challenges

- **Death was not due to the incident that caused the hypothermia; and therefore not an offence under HASWA**

CORONERS verdict

Cause of death was broncho-pneumonia due to decreased mobility following an episode of hypothermia on 25/26 November 2009 with dementia as a contributory factor

Death not due to hypothermia (cont)

- **To demonstrate deterioration of Mrs Spicer's health and capabilities including**
  - Mobility
  - Personality
  - Eating
- **By detailed examination of**
  - Medical history prior to incident from Care Plan and GP statement
  - Medical history from hospital records from 25/11/09
  - Staff interviews

Defence challenges

- **Abuse of process**
  - Time delays due to
    - CPS decisions
    - Pathologists
    - Coroners court
    - Waiting for evidence from police
    - Defence moving court dates

Lessons learnt

- **Incident could have been prevented by**
  - Having simple, effective systems eg bedtime checks
  - Recognising complacency from staff and managers
  - Staff carrying out their duties properly
  - Staff communicating to managers
  - Managers listening to staff
  - Employing staff who are competent for the duties required
  - Understanding and maintaining alarm systems

Thanks to

- The family
- DS Graham Cunningham — Lincolnshire Police
- Bernard Thorogood — No 5 Chambers, Birmingham
- Paul Rushworth — SKDC Legal team
- SKDC Commercial Team

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