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IN THE CORONERS COURT IN NORTHERN IRELAND

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BEFORE THE CORONER OF NORTHERN IRELAND
LOUISA FEE

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IN THE MATTER OF AN INQUEST TOUCHING UPON THE DEATH OF WILLIAM VICTOR McLEAN

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FINDINGS

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Introduction

[1] Before I begin to deliver my findings with respect to the death of William Victor McLean (known as Victor), I wish to reiterate my condolences to his entire family circle and, in particular his son, Alan McLean, who attended throughout the inquest proceedings.

[2] I am grateful to those witnesses who attended and gave evidence to the inquest. I also utilised my powers under the Coroners Practice and Procedure Rules (Northern Ireland) 1963 to admit a number of statements and records under Rule 17. It is not possible to recite all of the evidence in these findings but let me be clear that all of the evidence received by me has been considered before arriving at these findings.

[3] Victor McLean who was born on 24 November 1943, died in Antrim Area Hospital on 23 October 2022 when he was 78 years old. At the time of his death Mr McLean was a resident of Rose Court Care Home (also referred to as 'the Home') in Ballymena Co. Antrim.

[4] Mr McLean, who I will refer to as the deceased, moved into Rose Court Care Home on 27 March 2021 and became a permanent resident on 8 May 2021. He was placed under the care of the Permanent Placement Team in December 2021 and was in a residential dementia facility, due to his diagnosis of vascular dementia, from October 2019. He was subject to a 'Deprivation of Liberty' under the Mental Capacity Act (Northern Ireland) 2016.

Summary of evidence

[5] Mr Alan McLean, the deceased's son, gave evidence to the inquest describing the deceased as well regarded both professionally and personally. Mr McLean explained that following the diagnosis of dementia in October 2019, he and his family began to notice a deterioration in the deceased's cognitive function whereby he would often repeat conversations and household bills were unpaid. The deceased was also found wandering on occasion by friends and neighbours, prompting his admission to Rose Court Care Home. As this coincided with Covid-19 (Covid) restrictions, Mr McLean and his family were not initially permitted access to the Care Home beyond the car park. Over time, this progressed to pre-arranged visits and often if a positive case of Covid was identified within Rose Court Care Home, all visits would be suspended. Mr McLean explained that this meant there were large periods of time when the family would have been unaware of the care being provided to the deceased and, in any event as all visits were pre-arranged, the deceased was generally presented as tidy and well dressed.

[6] Mr McLean said that as Covid restrictions relaxed, he and his family were able to visit the deceased unannounced and this was when they began to have concerns about his care. Mrs Helen McLean, whose evidence was admitted under Rule 17, said that at times the deceased appeared unkempt and that he lost a significant amount of weight quickly, which the Care Home attributed to 'sunset syndrome'. A syndrome where the deceased was up and walking around during the night and sleeping all day. This resulted in the deceased missing mealtimes. Mr McLean described an incident in September 2022 when he attended Rose Court Care Home unannounced and was unable to locate the deceased. He was subsequently found in another resident's bed and appeared to have urinated on himself, his trousers were undone and he had a white tablet stuck to the outside of his mouth. Mr McLean said this was the first occasion he observed the deceased becoming aggressive and explained that he was shocked by his overall presentation. Ms Judith McLean, whose evidence was admitted under Rule 17, said that she raised concerns on behalf of the family with the manager of Rose Court Care Home and requested an investigation of the incident.

[7] Mr McLean told the inquest that the deceased's family were concerned about the frequency of falls he was having within the home. Mr McLean explained that he was aware the social worker was trying to identify a more appropriate care setting, however, the deceased was not considered sick enough for a nursing home and was too mobile for a residential home. He said he and his family were aware that the deceased required 'one to one care'. Helen McLean said that there was a fall which resulted in the deceased being admitted to Antrim Area Hospital on 3 September 2022. On this occasion hospital staff were struggling to stop him mobilising and, in her view, the hospital was aware he required one to one care and proceeded to discharge him to Rose Court Care Home where this was not available. She said that the deceased suffered another fall which resulted in him being re-admitted to

hospital on 15 September 2022 with a bleed on the brain. She explained that the hospital advised that a further fall could be catastrophic, however, they persisted in discharging the deceased to Rose Court Care Home again.

[8] In his evidence, Mr McLean said that Mr Krystof Ossowski from Rose Court Care Home contacted the family following this discharge and said they weren't happy that the deceased had returned to their care, as he was difficult to monitor and care for. He said they were advised the deceased would be moved into a room closer to the nursing station, however, this was never facilitated. Helen McLean explained that the deceased suffered his fatal fall on 20 October 2022 and there was some discrepancy in the explanation provided by Rose Court Care Home as to how the fall took place. She was also concerned that Mr Krystof Ossowski told her that he had not appraised attending paramedics of the deceased's previous fall and brain bleed. Mr Timothy McLean, the deceased's grandson who gave evidence to the inquest, said that he attended Antrim Area Hospital on 20 October 2022 and observed the deceased in the back of an ambulance waiting admission. He described the deceased as agitated and confused and unkempt in appearance. He said he had a large bump on his head which had been bleeding and a further abrasion on the bridge of his nose. He confirmed that the paramedics were unaware of the deceased's recent fall and brain bleed. He also said paramedics were sceptical of the explanation provided by Rose Court Care Home as to how the deceased sustained the fall. He said they thought it unlikely that he had fallen from a chair, as the injuries sustained were more likely due to a fall from standing.

[9] Ms Lynda Hayburn, social worker in the Permanent Placement Team, Northern Health and Social Care Trust (the Trust), gave evidence to the inquest. She explained that she became concerned about the care being provided to residents in Rose Court Care Home in and around the spring/summer of 2022. She said that her concerns were primarily around staffing and the lower staff to patient ratio. She said this had a knock-on effect on personal care and the standard of care provided whereby she observed patients unkempt and dirty. She said they often smelt of defecation and their clothes were saturated with urine. Ms Hayburn said she also had concerns around care planning and that the patient's care plans were not being appropriately updated to reflect their care needs. She believed that there was ineffective governance within Rose Court Care Home and that management was not accessible to staff at that time. In response to these concerns, Ms Hayburn said she performed unannounced visits to Rose Court Care Home and consistently escalated concerns within her management structure.

[10] Ms Hayburn described the deceased to have suffered significant weight loss with a poor sleep pattern, whereby he was awake during the night and sleeping during the day. In her view, he was not supported with appropriate nutritional input as he was asleep during mealtimes. She opined that junior staff within Rose Court Care Home required more support and assistance with provision of nutrition and fluids to residents. Ms Hayburn described attending Rose Court Care Home on 7 September 2022, where she observed the deceased sitting on a chair,

doubled over, sleeping. She recognised that he was at risk of falling over, out of the chair and potentially sustaining a head injury. In her view, staff should have placed the deceased into bed, where he could sleep safely. She brought her concerns to the attention of the care team leader in Rose Court Care Home at that time, Ms McAnally. Ms Hayburn described Ms McAnally as relatively junior and inexperienced and ill-equipped to deal with situations arising within Rose Court Care Home, albeit she felt her concerns were listened to and taken onboard. On this occasion, Ms Hayburn said a discussion took place about moving the deceased closer to the 'nurse station' so that he could be more closely monitored. This move would have required another resident to swap bedrooms with the deceased. However, Ms Hayburn said she was unaware of any discussion in this regard taking place with management, as the deceased did not move bedrooms at any time prior to his death.

[11] Ms Hayburn told the inquest she was so concerned about the deceased's presentation on 7 September 2022, that she believed an assessment of his nursing needs was warranted and it was her responsibility to progress that. Ms Morrison a community psychiatric nurse was appointed on the same date to complete the assessment, which took place on 13 September 2022. In her evidence, Ms Morrison said that the referral noted an increased number of falls, a recent hospital admission and an overall progression in dementia symptoms. She said her assessment considered the deceased's activities of daily living and what level of assistance he required. This included all aspects of personal care, mobility, feeding and whether his identified needs could be met in the care setting of Rose Court Care Home. She explained that his increased incidence of falls was considered as part of the assessment but said that a nursing placement would not prevent falls entirely. Ms Morrison detailed that the outcome of her assessment was that, although the deceased was currently placed in a registered dementia residential unit, his needs were at a level that he required a dementia nursing placement. She explained that this uplift in care was due to him requiring the assistance of two staff members for all aspects of personal care, which was beyond the level of care provided in a residential setting. In her evidence, Ms Morrison said that it was important this change in care was acted upon quickly, although she acknowledged that it can be challenging to identify available beds in appropriate units. She also confirmed that she was aware that there were concerns around the care being provided to patients in Rose Court Care Home, particularly in relation to staffing levels and the cleanliness of the Home.

[12] Ms Hayburn told the inquest that the deceased had an unwitnessed fall in Rose Court Care Home on 15 September 2022, which resulted in him being admitted to Antrim Area Hospital, having sustained a subdural brain bleed. During his time in hospital, his medications were reviewed and some ceased. Ms Hayburn explained that the deceased was discharged by the hospital back to Rose Court Care Home on 19 September 2022, despite a nursing assessment having been completed. She said that although she would usually be involved in decision making around complex discharges, such as this one, she had not been on this occasion as it was a

bank holiday. In her view, he should not have been discharged to residential care and if she had been consulted, she would have said it was an unsuitable discharge.

[13] In her evidence, Ms Hayburn said that thereafter her primary task was to secure a suitable nursing placement for the deceased and that this was a challenging undertaking, as there are too many patients and too few beds to accommodate them. She explained that she made a funding application for the uplift in care to a nursing placement on 20 September 2022. In his evidence, Mr Martin Millar, social worker, said he considered this application and forwarded it to Ms Maura Kelly, the locality manager, who approved it on the same date.

[14] Ms Hayburn said she observed the deceased sleeping unsafely in a chair in the lounge area of Rose Court Care Home on 21 September. She had a discussion with Ms McAnally, who said his mobility had been poor and he had been awake most of the previous night. Although Ms McAnally told her they were keeping a vigilant eye on the deceased, Ms Hayburn was of the view that he was being maintained in the lounge area as there were not enough staff on duty. Ms Hayburn was clear in her evidence that the deceased needed to sleep when he needed to sleep, and not when staff wanted him to.

[15] Ms Hayburn described to the inquest the significant efforts she made to identify a suitable nursing home placement for the deceased over the next number of weeks however, this endeavour was complicated by the specific care needs of the deceased, his high risk of falls and his ability to mobilise. Ms Hayburn was contacted by Ms McAnally on 17 October 2022, advising that the deceased had suffered another fall. She also relayed that Rose Court Care Home were struggling to provide care for the deceased. Ms Hayburn contacted Mr Millar on 18 October 2022 and highlighted the difficulties she was experiencing in finding a suitable alternative placement for the deceased. I pause to note that she had contacted at least 17 nursing homes.

[16] In his evidence, Mr Millar said he received a bespoke application from Ms Hayburn on 19 October 2022 seeking one to one care for the deceased, which he forwarded to Ms Kelly for consideration and approval, who then subsequently escalated the application to Ms Tanya Carson, head of service for approval. Mr Millar said he received email correspondence from Ms Carson on 20 October 2022 seeking further information about what risk reducing strategies had been implemented in Rose Court Care Home. Ms Hayburn told the inquest she had a discussion with Ms Elizabeth Craig, social work lead and area manager, about the deceased's care on 19 October 2022 and they both agreed it was an appropriate request in order to safeguard against the deceased potentially suffering a catastrophic fall. In their evidence, both Ms Hayburn and Ms Craig described one to one care and support and acknowledged that, although it wouldn't entirely remove the risk of falls, it would mitigate against the risk. Both witnesses also candidly acknowledged that one to one care could have been considered at an earlier stage.

[17] In her evidence, Ms Carson said that upon receipt of an application for one to one care and following scrutiny, she escalates the request to the Assistant Director of the Trust. She detailed that relevant factors for consideration were funding and what was the least restrictive option in accordance with 'Deprivation of Liberty legislation'. Ms Carson explained that she expected assistance to be provided to individuals around their activities of daily living within the standard care setting. She said the emphasis in the application in relation to the deceased was on falls, without information on additional needs, which was why she sought clarification on what risk reducing strategies had been implemented at Rose Court Care Home. Ms Hayburn said that the email from Ms Carson stated that much of what had been outlined in the application, should be care that is delivered as standard within a care home. Ms Carson was not clear in her evidence as to whether she had been aware that the deceased had previously been assessed to require a nursing placement and said she understood the application was in relation to provision of care in Rose Court Care Home. Ms Carson was unable to provide time scales for a decision in respect of such an application, however, she explained that there were now different processes in place whereby a weekly meeting takes place of the 'Senior Management Panel' to consider bespoke one to one care requests.

[18] Ms Hayburn told the inquest that she had a telephone conversation with the Clinical Lead at Rose Court Care Home, Ms McWilliams, on 19 October 2022, during which she advised of the one to one care application. Ms McWilliams told her that it was increasingly difficult to staff one to one support due to staff shortages and the reliance on agency workers. Ms Hayburn said she reiterated her previous request to have the deceased moved closer to the nurse station and reminded of the need for close supervision to mitigate against the risk of falls.

[19] Ms Zara Cousins, deputy sister at Antrim Area Hospital, gave evidence to the inquest. She explained that she was designated floating nurse on 19 September 2022 to provide support across the ward and was not assigned to the care of any particular patient. She said she facilitated the discharge of the deceased following a medical review, as he was deemed medically fit for discharge by medical staff. Ms Cousins said she spoke to the deceased's next of kin and was made aware that he had been assessed for an uplift to nursing care in the community rather than residential care in Rose Court Care Home. She explained that as it was a bank holiday, she contacted the duty hospital social worker who was covering Floor B, however she was unable to identify who this social worker had been. Ms Cousins said that she relayed that the deceased was medically fit for discharge and the information about the uplift to nursing care. She said that she was advised to continue the discharge if Rose Court Care Home were acceptant of his return. She said she spoke to Rose Court Care Home who accepted verbal handover and return of the deceased.

[20] In her evidence, Ms Cousins accepted that she had not reviewed the deceased's nursing records and acknowledged that this had been a critical oversight, as it was documented that he was on one to one supervision within the hospital

setting. Ms Cousins explained that one to one care is now referred to as enhanced care and described that in such circumstances, staff would remain with the designated patient throughout the day. She detailed that determination of this level of care usually occurs on admission and is considered by nursing staff, who are also mindful of the Deprivation of Liberty provisions. She said that there are processes in place that would usually highlight that a patient was on one to one supervision, such as the morning safety briefing which included patients on 'Do Not Resuscitate' status, enhanced care with feeding, falls risk and one to one supervision. She explained that it would also be detailed at nursing handover or staff allocation and she would further have been alerted if the deceased had been placed in in a bay close to the nursing station.

[21] Ms Cousins acknowledged that the requirement for one to one supervision meant that discharge to residential care was not a safe and effective discharge and had she realised this, she would have told the duty hospital social worker and made enquiries if Rose Court Care Home had one to one available in the home. With reflection Ms Cousins said the requirement for one to one supervision would have changed her clinical judgement, and she would have questioned discharge to a residential home as she recognised this level of support was not available and would have resulted in a failed discharge. In her evidence, Ms Cousins could not recall if staff at Rose Court Care Home had expressed any concerns about the deceased's return, but she thought it was unlikely that they had as this would have prompted her to have a further conversation with the duty hospital social worker.

[22] Dr Ursula Griffiths, consultant in acute medicine, gave evidence to the inquest. She said she conducted a review of the deceased on 19 September 2022 and noted that he had an acute subdural haematoma secondary to falls and was not for neurosurgical intervention. Following her review of the deceased's medications, she stopped numerous drugs that may have been contributing to his falls risk. Dr Griffiths explained that in her view, the deceased's falls were multi-factorial in nature whereby he had an impaired safety perception due to his vascular dementia and his polypharmacy. She said changing the medication regime was a balancing exercise, as she wanted to minimise the increased risk of falling against the need to manage his other medical conditions. Dr Griffiths said she concluded that the deceased was medically fit for discharge and documented within the notes that he required an uplift to nursing care. In her evidence, Dr Griffiths was unable to recall where the recommendation in respect of nursing care had originated but was of the view that someone else had told her this.

[23] Ms Anita White, service lead for 'Hospital Social Work', gave evidence to the inquest. She explained that a formal referral for the deceased was not made to Hospital Social Work by community staff or acute nursing staff. She said that following review of the staffing rota for 19 September 2022, there is no one who recalls having a conversation about the deceased or his discharge nor is there any record of whom Ms Cousins spoke to.

[24] In her evidence, Ms White hypothetically said that if she had known that the deceased required a nursing placement, this was likely to have prompted further referral or assessment, rather than knowledge of the one to one supervision being provided in the hospital setting. In her view, if she had been informed that the deceased was at his baseline level of function and the residential home had no issues with his return, she would not have had concerns around his discharge.

[25] Dr Paul Mogey, whose evidence was admitted under Rule 17, said that the deceased had been admitted to Antrim Area Hospital on 20 October 2022, following a fall in his nursing home, which had resulted in an acute on chronic subdural Haematoma injury to his brain. He said he was informed of the deceased's previous fall on 15 September 2022, which resulted in a subdural haematoma. Dr Mogey said he documented a discussion between Dr Calvin and the neurosurgical registrar in the Royal Victoria Hospital, who advised conservative management of the intracranial injury. He said a Do Not Resuscitate Order was completed with the agreement of the deceased's next of kin on 20 October 2022. On examination, Dr Mogey said that the deceased was unable to answer four acute mental test questions of recalling how old he was, his date of birth, the current year and his current location. He said he detailed an investigation and management plan for the deceased and documented a diagnosis of acute on chronic subdural haematoma.

[26] Dr Joshua Boal, physician associate, whose evidence was also admitted under Rule 17, said that he was the scribe on the 'consultant post take ward round' on 21 October 2022. He said that the deceased had a diagnosis of acute on chronic subdural haemorrhage and following discussion with neurosurgery, was for conservative management. This evidence was reflected in the evidence of Nurse Emma McElhatton, which was admitted in accordance with Rule 17. She said that the deceased was admitted for end-of-life care and the priority was comfort care with no observations being completed. Nurse Kelly in her evidence admitted under Rule 17, said that she was the 'Hospital at Night Team' clinical nurse coordinator on 23 October 2022. She attended Ward B5 at 22:15 hours and conducted a thorough assessment of the deceased, to verify his life extinct.

[27] Mr Krystof Ossowski, former unit manager at Rose Court Care Home, gave evidence to the inquest. He said that he worked at Rose Court Care Home between July 2011 and October 2023. He was responsible for the management of 'Maine Unit', which was a dementia unit with capacity for 29 residents. He said his role was primarily office based, dealing with rotas, admissions, other healthcare workers, medications and care plans. In addition, he would also provide care and support to the residents. In his evidence, Mr Ossowski said he had been aware of the Trust's concerns in respect of the care being provided within Maine Unit. Although he was responsible for staffing rotas, he explained that he had no control over the number of staff allocated to Main Unit, as this was a determination for senior management. He said it had been difficult to ensure the Maine Unit had enough staff on duty, especially during the Covid pandemic, when there was a lot of staff sickness and an over reliance on agency workers. In his view the main impact of staff shortages was

the stress this placed on other staff members and more could have been done by management to provide support in this regard.

[28] In his evidence, Mr Ossowski was unable to recall specific details about the deceased's time in Maine Unit and explained that his statement had been collated from nursing notes pertaining to the deceased. He denied that special efforts were made to ensure residents appeared well cared for when relatives were visiting and described the deceased to often refuse assistance with activities of daily living. In circumstances where a patient has been assessed to require nursing care, he detailed that further precautions would have been taken and explained that checks of medical conditions and presence of infection would be undertaken with mobility assessments. He thought staff would be aware from handover if a patient required increased care and supervision. Mr Ossowski was unable to recall if the deceased's care plan was updated following his assessment to require nursing care but believed it would have been. He could also not recall if staff were advised to place the deceased in bed rather than permit him to sleep in a chair, however, he thought such information would be communicated during handover.

[29] In relation to the deceased's discharge from hospital on 19 September 2022, Mr Ossowski was of the opinion that even if Rose Court Care Home had refused to facilitate his return, the hospital would have sent him back to them regardless. He was clear however, that in circumstances where a patient was assessed as requiring nursing care, they should not be returned to residential care. Mr Ossowski had no recollection of any discussions within Maine Unit about potential one to one supervision of the deceased and stated that this would not be a decision he could take without the input of senior management. He was also unable to recall the circumstances of the fall suffered by the deceased on 20 October 2022, however, he accepted that he had completed the accident form which stated that the deceased had an unwitnessed fall out of the chair in the lounge and hit his head and nose. Mr Ossowski said he could not remember paramedics attending or whether he had spoken to them and advised of the deceased's previous fall and subsequent brain bleed.

[30] Ms Colleen McWilliams, clinical lead, gave evidence to the inquest. She said she was employed at Rose Court Care Home from July 2022 until February 2023. Her role was to support the Rose Court Care Home manager with governance and audit and to improve on issues of concern that had been identified by the Trust, she also assisted with the Regulation and Quality Improvement Authority (RQIA) inspection. She said the Home manager left post in September 2022 when she took over as acting manager for a short period. In her evidence, Ms McWilliams disagreed that Rose Court Care Home had been short staffed and in her view any problems were created by staff advising they were unwell at short notice. She said her emphasis was to put in place those systems the Trust were seeking and advance recruitment procedures. She explained that to address any shortage in staff they would have asked other staff to cover increased hours or employ agency staff on a

block booking basis. She said that RQIA agreed the required level of staff in Maine Unit was five staff in the morning and four in the afternoon.

[31] Ms McWilliams told the inquest the deceased was regularly checked due to his high risk of falls and said there was an increasing concern about the propriety of his placement in Rose Court Care Home due to the level of support he required. In her evidence, she explained that initially Rose Court Care Home established if the changes in the deceased's condition were acute or chronic in nature. She said that they needed to rule out acute causes such as diabetes or an infection. She said she discussed the deceased's presentation with Ms Hayburn and considered changes in medications to reduce the risk of falls. In her opinion, the deceased had difficulty tolerating other people in his close personal space.

[32] Ms McWilliams said that she was aware that the deceased had a tendency to sleep in inappropriate places such as chairs in the lounge and that this was considered unsafe. She said staff were aware that they should assist him to bed, however, she said that they were unable to use lifting equipment and can't forcefully place a patient in bed therefore they could only try and rouse him and get him into a wheel chair to transfer him to bed. She accepted that she had been unable to identify anything in relation to these sleeping arrangements in the deceased's care plan and acknowledged that it should have been in his care plan. Ms McWilliams stressed in her evidence that it was not practical for a staff member to be with the deceased at all times and there was no obligation to ensure that staff were present in the lounge area to provide constant supervision.

[33] In her evidence Ms McWilliams agreed that there must have been some discussion between Rose Court Care Home and the hospital in relation to the deceased's discharge on 19 September 2022. However, in her opinion his needs had become more complex with him having suffered a brain bleed and he should not have been discharged to residential care. She explained that once he returned to their care, it was their responsibility to keep him as safe as possible. Ms McWilliams recalled a discussion around one to one supervision but said that Rose Court Care Home did not have sufficient staff to facilitate this. She explained that they were already facilitating increased supervision with 15-minute checks during the day and 30-minute checks at night and ramble guards were in place. She said Rose Court Care Home did not have the scope to provide anything further to the deceased. Ms McWilliams said she told the Permanent Placement Team on 17 October 2022 that they could no longer accommodate the deceased as they were unable to meet his needs.

[34] Ms Andrea Harkness, senior manager of Rose Court Care Home, gave evidence to the inquest. She said she has been employed at Rose Court Care Home as a manager since December 2023 and was not in post either at the time of the deceased's death or during his time as a resident. She explained that she has management responsibility for both the care home and the nursing home, whereas both units were previously under separate management. She said that following the

commencement of her role a 'Service Improvement Plan' was put into place to address concerns raised by the RQIA. The plan comprised ensuring allocation of staff to personal care and ensure all care is provided with notes recorded of when residents refuse care and consideration of actions thereafter, handwashing audits and review of PPE use. Newly recruited staff are to be buddied up with more experienced staff for support and weekly supervision is to be carried out to ensure staff development.

[35] Ms Harkness said in circumstances where a patient was suffering an increased frequency of falls, the adopted procedure would be to initially consider if there was an infection and if an acute cause could be ruled out, then there should be progression to a nursing assessment. She explained that any application for one to one supervision was the responsibility of the social worker rather than care assistants in Rose Court Care Home, who are not clinically trained. In Ms Harkness' view, if the deceased's care needs had changed following his fall on 13 September 2022, he should not have returned to residential care. She opined that if the hospital contacted her now in similar circumstances, she would strongly resist an inappropriate discharge. Ms Harkness told the inquest that under her management regime, care plans are reviewed periodically with 10% of all plans being considered on a monthly basis.

[36] Ms Diane Spence, divisional director of community care in the Trust, gave evidence to the inquest about the 'Significant Event Audit' (the SEA) process, which was undertaken by the Trust following the deceased's death. The findings of the SEA identified twelve key learning points with nine recommendations for the Trust and six for Rose Court Care Home. She said the Trust had accepted the recommendations and had developed an action plan to address their implementation.

[37] In short summary, Ms Spence said that the Permanent Placement Team have established weekly meetings to review all concerns arising in care homes, as part of a wider 'Care Home Support Reform' project. Regional 'Falls Guidance' has been issued which can be used by care home staff in the event of a resident experiencing a fall. It also provides instructions on steps to be taken following a fall, regardless of the severity of that fall. There is now a process in place which enables the agreement of urgent one to one supervision with the ability to seek financial approval retrospectively. In her evidence, Ms Spence explained that there was available guidance for staff about how to request and seek approval of one to one supervision and on what is expected from the care home in provision of enhanced care. The Trust have established an 'Enhanced Care Oversight Group' and she explained that 'enhanced care' generally means the enhanced supervision of a patient through cohort care or via additional supporting staff. This may be one to one intervals or continually or two to one or greater.

[38] Ms Spence told the inquest that the 'Shared Decision Panel' meet on a weekly basis to consider all requests for enhanced care and, in her view, this process

prevents delay in decision-making for enhanced care as experienced by the deceased. Ms Spence agreed that the request for one to one care for the deceased should have been accelerated.

[39] Ms Spence said that since the deceased's death the 'Enhanced Patient Care Observation Assessment Tool' has been developed and implemented within the acute wards of both Antrim Area and Causeway Hospitals. This tool focuses on patient safety and individual needs and provides a platform to determine if enhanced care is needed, it also informs decisions around appropriate discharge arrangements.

[40] In her evidence, Ms Harkness said that recommendations arising from the SEA in relation to Rose Court Care Home had been taken on board and in short summary, she confirmed that management will attend an acute setting to assess if a patient can safely return to Rose Court Care Home. She said that new pathways had been implemented whereby step by step guidance was available for how to deal with falls in Rose Court Care Home and she said that an external training provider had been sourced to provide training on how to complete and maintain resident care plans. Ms Spence said that the Permanent Placement Team were undertaking a random sample audit of care plans in Rose Court Care Home to ensure they were in accordance with individually assessed needs. The Permanent Placement Team will also carry out intermittent checks of the post falls observation forms, to ensure falls are recorded and sufficiently detailed.

Conclusion

[41] In coming to my conclusions, I have considered all of the evidence heard and received by me in the course of the inquest and was greatly assisted by the witnesses who attended and gave evidence. I would like to remind everyone that I make each of my findings on the balance of probabilities (ie. what is more likely than not).

[42] I find that the deceased, William Victor McLean, died in Ward B5 at Antrim Area Hospital on 23 October 2022. On the evidence before me, I find that there were a number of missed opportunities and failings in the care and treatment of the deceased, in the months leading up to his death, which I outline below.

[43] The deceased became a resident of Rose Court Care Home on 27 March 2021 and was placed under the care of the Permanent Placement Team in December 2021. His placement at Rose Court Care Home was because it was considered to be a residential dementia facility which was appropriate for the deceased, who had a diagnosis of vascular dementia.

[44] I find that the care provided to the deceased within the residential unit of Rose Court Care Home, during the latter part of 2022, was wholly inadequate and unsatisfactory. I accept the evidence of the McLean family that they often observed the deceased in an unkempt condition with little or no attention given to matters of

personal care. Their evidence was compounded by Ms Hayburn who said she had observed patients within Rose Court Care Home unkempt and dirty, who often smelt of urine or defecation. It is particularly striking that Mr McLean located the deceased, on one occasion, on the bed of another resident, having urinated on himself, with a white tablet stuck to the side of his mouth. I find that there was little regard for the deceased's well-being in these circumstances and it is clear to me that he was not sufficiently supervised at this time.

[45] I accept the evidence of Ms Hayburn that the deceased was losing significant weight over this time period due to suffering sunset syndrome whereby he was sleeping during the day and awake and wandering during the night, which resulted in him often missing mealtimes. I also accept Ms Hayburn's evidence that the deceased's sunset syndrome resulted in him being tired and sleepy during the day, and I find that he was often left to inappropriately sleep in chairs in the lounge area. The inquest heard evidence that the lounge area is not subject to constant supervision and it is unsatisfactory that the deceased was left to sleep in such an unsafe position, as evidenced by the fatal, unwitnessed fall he suffered on 20 October 2022 which was attributed to him falling forward out of a chair. I accept Ms Hayburn's evidence and find that Rose Court Care Home should have facilitated the deceased to sleep when he needed and wanted to, regardless of whether this required rousing him and safely moving him to his bed.

[46] I accept Ms Hayburn's evidence and find that care plans were not appropriately updated in Rose Court Care Home to reflect a patient's care needs. It was of some concern that Ms McWilliams said in her evidence that issues around the deceased falling asleep in a chair should have been detailed in his care plan, but she was unable to identify anywhere it was noted. The inquest heard evidence that the most challenging aspect of care provision in Rose Court Care Home was availability and sickness levels of staff. I accept Ms McWilliams evidence that the Maine Unit was staffed with the minimum number of persons recommended by RQIA guidance however, in accordance with Ms Hayburn's evidence, I find that staff who were present, lacked the experience and skills required to appropriately meet and understand the care needs and complexities of a dementia patient such as the deceased. I accept Ms Hayburn's evidence that there was ineffective governance within Rose Court Care Home and on the evidence considered by me there does not appear to have been sufficient senior management input and support provided to inexperienced staff members. I find that there should have been a comprehensive care plan in place relating to the deceased which reflected his evolving and changing need particularly as his risk of falls increased. I find that the deceased's care needs fundamentally changed following his assessment to require nursing care on 13 September 2022. This assessment having been prompted by the deceased's increased number of falls and an overall progression in dementia symptoms.

[47] The inquest heard evidence that the deceased was admitted to Antrim Area Hospital on 15 September 2022, following an unwitnessed fall in Rose Court Care Home which resulted in him suffering a subdural brain bleed. He was subsequently

discharged back to Rose Court Care Home on 19 September 2022. I find, and as candidly accepted by Nurse Cousins, she failed to read and consider the deceased's medical notes and records before proceeding with his discharge from hospital. I find that although she was aware that the deceased had been assessed as requiring a nursing placement following a discussion with a family member, she nevertheless proceeded to action a discharge to residential care. This is particularly concerning as the brain bleed suffered by the deceased could only have increased his needs beyond those assessed on 13 September 2022. I find that Nurse Cousins' failure to appropriately consider the deceased's notes resulted in her being unaware that he had been subject to one to one supervision in the hospital. I accept her evidence that this was a critical oversight and I further accept that had she known of this requirement she would not have progressed his discharge back to Rose Court Care Home as it would not have been a safe and effective discharge.

[48] On the evidence considered by me it is not possible to be satisfied that a discussion took place between Nurse Cousins and the duty hospital social worker about the deceased's discharge, however, I accept the evidence of Ms White that hypothetically she would not have had any concerns about the discharge if she had been advised he was at his baseline level of functioning and the residential home had no issues with his return. Critically, this opinion does not address the reality of the deceased's condition at that time, whereby his care needs had increased in complexity and he was on one to one supervision in the hospital. I find that Nurse Cousins did have a discussion with Rose Court Care Home about the deceased's return on 19 September 2022 and I find that during this conversation the home did not express concern over his return, despite the contents of a daily report note referred to by Ms McWilliams in her evidence. I have no difficulty finding that the deceased was inappropriately discharged from the hospital back to residential care at Rose Court Care Home on 19 September 2022 and that this discharge should not have taken place without the involvement of the Permanent Placement Team in the community and further assessment of the deceased's needs.

[49] Following the deceased's return to Rose Court Care Home, I find that it quickly became apparent that they were unable to safely care for the deceased, as evidenced by Ms Hayburn observing him sleeping in a chair in the lounge area on 21 September 2022.I pause to reiterate the risk of falls associated with this sleeping arrangement. I also find that there was a missed opportunity to implement the advice of Ms Hayburn to move the deceased to a bedroom beside the nursing station which would have facilitated an increased level of monitoring and supervision.

[50] I acknowledge that Ms Hayburn made significant efforts to secure funding and identify an appropriate nursing placement for the deceased and that this was complicated by his specific care needs, particularly his high risk of falls and his ability to mobilise. I further acknowledge that following a fall by the deceased on 17 October 2022, Rose Court Care Home were communicating to Ms Hayburn that they were no longer able to cope with his increasing needs. I find that this incident prompted Ms Hayburn to seek authority for one to one care and supervision on

19 October 2022. I find that the process in place for authorisation at this time, caused unnecessary delay in providing the level of care the deceased required, with too much emphasis on resources rather than safety. I find that it should have been clear to management within the Trust that Rose Court Care Home was not the appropriate environment for the deceased, as evidenced by his assessment on 13 September 2022 that an uplift to nursing care was required, as he needed assistance beyond that provided in a residential setting. This was in my view, further compounded by the brain bleed he had suffered on 15 September 2022 and his continued inappropriate placement at Rose Court Care Home. Although I commend the efforts of Ms Hayburn, I find that there should have been earlier consideration given to one to one care and supervision for the deceased and particularly after his discharge to Rose Court Care Home on 19 September 2022. In their evidence, both Ms Hayburn and Ms Craig described one to one care and support and acknowledged that although it would not entirely remove the risk of falls it would mitigate against the risk.

[51] I find that the deceased suffered an unwitnessed fall in the lounge area of Rose Court Care Home on 20 October 2022 and I am satisfied that the most likely explanation is that he fell forward from a chair, striking his head and nose, as recorded by Mr Ossowski in the accident form. I find that Mr Ossowski failed to advise attending paramedics that the deceased had previously suffered a fall resulting in a brain bleed. I accept the evidence of Dr Mogey and find that the deceased sustained an acute on chronic subdural haematoma injury to his brain as result of the fall on 20 October 2022. I accept the evidence of all treating clinicians at Antrim Area Hospital and find that the treatment plan was for conservative management and end of life care. The deceased subsequently died at 10:15pm on 23 October 2022.

[52] A Medical Certificate of Cause of Death was completed by Dr Ismail which records and I find that death was due to:

1(a) Acute on chronic subdural haematoma

(b) fall

(c) vascular dementia

2 chronic subdural haematoma, ischaemic heart disease, type 2 diabetes mellitus

[53] The above findings should be considered in the following context: the inquest heard evidence from both Ms Spence who outlined the lessons learned following the deceased's death and Ms Harkness, the present manager at Rose Court Care Home, who detailed various changes which have been implemented at the home in the intervening period.

[54] I commend the Trust for the actions they have taken to remedy the issues and concerns which have been highlighted in this inquest and I am satisfied that various protocols and procedures have been implemented to minimise the risk of the failures associated with the deceased's death, happening again. I accept the evidence of Ms Harkness that steps have been taken to address the issues of concern within Rose Court Care Home and I acknowledge the progress made in this regard.