

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li>1. Isle of Wight NHS Trust</li><li>2. [REDACTED] – Clinical Governance at St Mary’s Hospital, Newport, Isle of Wight</li><li>3. Isle of Wight Adult Safeguarding Team</li><li>4. [REDACTED] - owner of Waxham House Residential Care Home#</li><li>5. Care Quality Commission</li></ol>
1	<p><b>CORONER</b></p> <p>I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.</p>
2	<p><b>CORONER’S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 14<sup>th</sup> April 2014 I commenced an investigation into the death of Barbara Monica May Cooke, aged 84. The investigation concluded at the end of the inquest on 9<sup>th</sup> September 2014. The conclusion of the inquest was “Natural causes contributed to by neglect”. The medical cause of death was found to be:</p> <ol style="list-style-type: none"><li>1a Multiple Organ Failure.</li><li>1b Septicaemia.</li><li>1c Infected Pressure Sores.</li></ol>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <ol style="list-style-type: none"><li>1) Barbara Monica May Cooke was born on 23<sup>rd</sup> May 1929. At the time of her death, she was 84 years of age.</li><li>2) She was a resident in Waxham House Residential Care Home. She had moved there in August 2012 having spent a short period in another Care Home which was unsuitable for her needs in that it specialised in caring for those with dementia. Waxham House is a 20 bed Care Home with the provision to care for 2 higher needs residents.</li></ol>

- 3) Mrs Cooke had a previous medical history of psoriasis, and since 2012, she had intermittent problems with sacral sores – particularly in her sacral cleft. These were addressed satisfactorily by the District Nursing team who appear to have visited her regularly as and when required. Towards the end of 2012, Mrs Cooke began to have incontinence issues, and by February 2014, she had become doubly incontinent.
- 4) Mrs Cooke's son ██████ visited his mother regularly and by Christmas 2013 was concerned that his mother wasn't being helped to the toilet as often as she required. He was concerned that with her psoriasis her skin was regularly broken due to the psoriatic lesions and if she didn't get to the toilet in time and soiled her incontinence pad, that there was the resultant increased risk of a skin infection. He was also concerned that his mother only appeared to have one slot a week where she was able to have a bath, and if she missed that slot for whatever reason, she was unable to have a bath until another week had elapsed. The Care Home claimed that it was the resident's choice when and if they bathed, and that Mrs Cooke was always provided with a strip wash on a daily basis. They also maintained that if she had wanted to bathe more frequently that this request could be accommodated.
- 5) By February 2014, ██████ was complaining to her son of having a sore bottom. Mr Cooke was concerned that he could see other residents being left for up to an hour before being taken to the toilet by the staff.
- 6) Mrs Cooke saw a Consultant Dermatologist in March 2013, in the company of her son ██████ about her worsening psoriasis. She was prescribed the immuno-suppressant medication Methotrexate.
- 7) ██████ visited his mother at Waxham House on 30<sup>th</sup> March. He found her in a highly distressed state, asking to be taken to the toilet. She had soiled herself and had faeces on her face. He was very shocked to find her in that state. One of the other residents in the Sun Lounge was in considerable respiratory distress. ██████ brought this to the attention to the 2 members of staff on duty at the time, but one of them was dealing with medication and claimed that she could not be disturbed and the other member of staff was busy with other matters. ██████ also asked them to take his mother to the toilet and to clean her, but the two members of staff were too busy to assist, and Mrs Cooke remained sitting in her own excrement for two and a half hours. Whilst waiting for assistance, the other resident collapsed and paramedics were finally called. They sought to resuscitate her in the Sun Lounge in front of the other residents as there appeared to be no staff available to move the residents to other

- 8) The following day, [REDACTED] brought his concerns about the way in which his mother was being treated to the attention of the Isle of Wight Adult Safeguarding Team.
- 9) Earlier on 1<sup>st</sup> April 2014, [REDACTED] the Manager of Waxham House, had completed a body map diagram of Mrs Cooke which showed that she had a sacral sore on her left buttock and a sacral tear in her natal cleft. [REDACTED] had called to ask the GP to visit to see Mrs Cooke. She did not speak with the GP, [REDACTED] directly, nor did she tell the receptionist to tell the GP about the sores on Mrs Cooke's buttock and in the natal cleft.
- 10) [REDACTED] had a consultation with Mrs Cooke and her son [REDACTED]. No-one mentioned to [REDACTED] that she had any sacral sores. [REDACTED] didn't know about these sores as he had not been informed by the Care Home that they existed and Mrs Cooke didn't mention them either. [REDACTED] believed that the purpose of the consultation was to deal with Mrs Cooke's evident distress after the events of the 30<sup>th</sup> March. [REDACTED] said in evidence that if he had been told about her sacral sores he would have asked to see them.
- 11) At some point on 1<sup>st</sup> April, [REDACTED] made a call to the District Nurse and claims that she asked her to visit Mrs Cooke. The District Nurse never visited her and enquiries with the District Nursing Service revealed that no request had ever been received in respect of Mrs Cooke. At no time did [REDACTED] follow up her initial call to the District Nurse with a further call to repeat the request that Mrs Cooke receive a visit for her sacral sores.
- 12) On 2<sup>nd</sup> April 2014 an unannounced visit was carried out to Waxham House by [REDACTED] a case manager from the IOW Adult Safeguarding Team as a result of the Safeguarding concern raised by [REDACTED].
- 13) On 4<sup>th</sup> April, a telephone conversation took place between with [REDACTED] (Mrs Cooke's GP) and [REDACTED], the Care Home Manager about Mrs Cooke, but no mention was made of her sacral sores. [REDACTED] was told that Social Services were requesting a mental capacity assessment by a GP for Mrs Cooke. Mention was also made of the death of the female resident the previous week, Mrs Cooke's lack of toileting and [REDACTED] referral to the Safeguarding team.
- 14) On 7<sup>th</sup> April 2014, [REDACTED] visited Mrs Cooke as she had deteriorated

- 15) Upon admission later that day, Mrs Cooke was found to have two Grade 4 pressure ulcers. Photographs taken at the time show full thickness necrosis of the tissue. Mrs Cooke's son accompanied her whilst she was being admitted and was told by a nurse that his mother had a very bad sore that should have been found and treated much sooner. Upon admission a diagnosis of sepsis was made. Fluids and antibiotics were commenced and samples for culture were taken.
- 16) ██████ made a further referral to the Adult Safeguarding Team on 8<sup>th</sup> April 2014 after his mother was admitted to St Mary's Hospital. A decision was made to appoint an Investigating Officer from Safeguarding to look into these new concerns.
- 17) Mrs Cooke was seen and treated by a number of medical professionals whilst in St Mary's Hospital including the tissue viability nurse. Surgical debridement was not indicated due to the frailty of the patient.
- 18) By 8.15 a.m. on 10<sup>th</sup> April 2014, Mrs Cooke had deteriorated further. She developed an acute kidney injury thought to be due to sepsis and a low platelet count (possibly due to the Methotrexate which she had been prescribed for her psoriasis.) A DNACPR was already in place and Mrs Cooke's family were advised of the gravity of the situation.
- 19) Mrs Cooke was confirmed as suffering from E. Coli septicaemia on 11<sup>th</sup> April 2014 and died at 3.05 p.m. later that day.
- 20) ██████ left a message for the IOW Adult Safeguarding Team on 14<sup>th</sup> April 2014, to follow up the issues he had raised, but he did not mention that his mother had died.
- 21) After Mrs Cooke died, it took 3 days for the IOW Adult Safeguarding Team to discover that she had, in fact, died.
- 22) The IOW Adult Safeguarding Team telephoned St Mary's Hospital on 14<sup>th</sup> April 2014 to enquire as to how Mrs Cooke was responding. It was only during this

23) The doctors treating Mrs Cook completed a Medical Certificate of the Cause of Death. The matter was brought to the Coroner's attention only when [REDACTED] was trying to register his mother's death and he mentioned his concerns to the Registrar. The Registrar referred the matter back to the Coroner for investigation on 14<sup>th</sup> April 2014.

24) The IOW Adult Safeguarding Team were telephoned by the Coroner's Office on 17<sup>th</sup> April 2014 asking for details of the Investigating Officer dealing with Mrs Cooke. They were contacted again by the Coroner's Office on 2<sup>nd</sup> May 2014 to inform them that the Coroner had opened an Inquest.

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**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. During the course of the evidence, it became clear that the resident to staff ratio of 20:2 during between 2 p.m. and 9 p.m. was inadequate to deal with all the residents' needs at Waxham House. (The staffing levels at other times also appeared inadequate for the numbers of residents.) The staffing levels did not allow for one staff member to safely distribute medication to the residents without interruption; provide teas for the residents and cater for their other reasonable needs in an acceptable timeframe. I was concerned that residents were being left for two and a half hours, sitting in their own excrement, waiting to be taken to the toilet and cleaned, and that there were insufficient staff to attend to a resident who was clearly dying. Moreover, I am concerned that there were insufficient staff members to escort residents away from a resident who was being attended to by paramedics, thereby denying this lady any dignity in her last moments.
2. I am concerned that the Waxham House Residential Care Home didn't recognise the obvious risks of infection of leaving an incontinent lady sitting in her own waste when she was prone to sacral sores, and almost certainly had at least one at the point at which she was left sitting in her own urine and excrement for two and half hours on 30<sup>th</sup> March 2014.
3. I am concerned that there appears to be no protocol at Waxham House to chase up the District Nurse Service if they haven't responded to a message within 24

	<p>4. I am concerned that there does not appear to be a system in place at St Mary's Hospital to record on admission that a patient is the subject of an open Safeguarding concern. (In this case, the subject of the Safeguarding alert was an adult, but this concern relates to both adults and children.)</p> <p>5. I am further concerned that there is currently no system in place at St Mary's Hospital to automatically contact the Coroner to refer the matter for investigation when a person who is the subject of a Safeguarding alert dies whilst an inpatient in the Hospital.</p> <p>6. I am concerned that there is currently no system in place at St Mary's Hospital to automatically notify the IOW Safeguarding Team if someone who is the subject of an open safeguarding alert dies whilst an inpatient in the Hospital.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 7<sup>th</sup> November 2014. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [REDACTED]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	 <p><b>H.M. Senior Coroner – Isle of Wight</b></p> <p><b>12<sup>th</sup> September 2014</b></p>