ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Medical Director, Royal Cornwall Hospital Truro** **2. [redacted] – Son & daughter-in-law of deceased**
1	**CORONER** I am an Assistant Coroner for the coroner area of Cornwall.
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.
3	**INVESTIGATION and INQUEST** Mrs Care died on 12 October 2013. An investigation was commenced on 21 October that year and culminated with an inquest before me on 9 June 2014. After the post-mortem the pathologist initially gave an "unascertained" cause of death. Having heard the evidence at inquest, [redacted] provided as the medical cause of death: 1(a) Bronchopneumonia 1(b) Multiple Myeloma (Clinically Treated) II Extensive Soft Tissue Haematoma
4	**CIRCUMSTANCES OF THE DEATH** In September/October 2013, Mrs Care was an 86 year old lady who her GP described as "frail and with very poor mobility". A clinical diagnosis had been made that Mrs Care was suffering from Multiple Myeloma but she declined a bone marrow aspirate which would have provided a conclusive diagnosis. Instead, Mrs Care opted for a course of steroids for symptomatic treatment. At the end of September she was admitted into Treliske and was extremely unwell, agitated and confused. She was found to have a possible urinary tract infection and steroid psychosis was suspected. She had an upper GI bleed and an endoscopy revealed an oesophageal ulcer. She required a blood transfusion. It is important to note that by this time Mrs Care was bedridden and doubly incontinent. She was admitted with a grade two pressure ulcer to her sacral area which improved during the course of her stay. After a week's treatment Mrs Care's acute condition had been stabilised. [redacted] gave evidence at inquest and explained how he felt Mrs Care could either be discharged home or to a community facility for rehabilitation. A decision was made to transfer her to Helston Hospital and this took place on 9 October.

	It is worth noting that during her admission in Treliske a decision was made by [redacted] to put in place an "Allow Natural Death Order". Although he asked junior members of his team to communicate this decision to the family this was not done. This is something that I see repeatedly at inquest and it causes considerable distress to members of the deceased's family. On arrival at Helston Mrs Care was subject to standard nursing assessments. At this time a large bruise was noted on her right hip. The family were informed who knew nothing about how this had occurred. The family attempted to ascertain what had happened by contacting staff at Treliske. None of their calls were returned. A nurse at Helston was able to speak to colleagues at Treliske. Having reviewed the nursing notes and records there was nothing in them that could explain how the large bruise had been caused. This was notwithstanding the fact that as she was doubly incontinent she must have been washed prior to discharge at which time the bruising should have been obvious. I enclose, for your information, a copy of the statement of [redacted] and direct your attention to paragraph 14 of it. Although the family had been told Mrs Care was to go to Helston for "rehabilitation" she steadily and rapidly deteriorated and died on 12 October. This came as a shock to them.
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. – At inquest I found as a matter of fact that it was more likely than not that trauma caused the extensive bruising seen on Mrs Care's hip and abdomen at post-mortem. I further found that it was more likely than not that this trauma was sustained during Mrs Care's stay in the Royal Cornwall Hospital. Evidence was read out at inquest that nothing untoward happened during the ambulance transfer. The bruising itself was discovered at the time of Mrs Care's admission into Helston Community Hospital. I was not able to offer the family an explanation at inquest as to how this trauma had been sustained. That is plainly undesirable and it is for this reason that I write to bring this matter to your attention. You will understand that the pathologist found the extensive soft tissue haematoma was contributory to Mrs Care's death, something the family described as "a sad state of affairs". During the course of the inquest it was drawn to my attention that owing to the fact Mrs Care had become immobile she was being moved with a hoist. It was speculated that this may be the cause of the bruising that was seen. I had no evidence, however, from anyone who had been involved in moving Mrs Care by this means.
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.

	In the first instance I would be grateful if you would look again to see if there are any further enquiries that can be undertaken that may provide an explanation as to how this trauma was caused. In particular, would you please identify those individuals involved in hoisting Mrs Care before her discharge and see if any of them are able to offer an explanation as to how the bruising may have been sustained.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday, 11 August 2014. 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 the family of the deceased 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	**16th June 2014** **Andrew J Cox, Assistant Coroner**