REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive Officer , Blackpool Teaching Hospitals NHS Foundation Trust and to The North Shore Surgery, Blackpool.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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** On **2nd December 2013** I commenced an investigation into the death of **AUDREY VERA GARLAND** dob **31st December 1935**. The investigation concluded on the **25th April 2014** and the conclusion was one of **a narrative verdict**. The medical cause of death was **1a Bronchopneumonia 1b Ischaemic gangrenous ulceration of the legs and feet 1c Peripheral vascular atherosclerosis 11 Coronary artery atheroma, Hypertension.**
4	**CIRCUMSTANCES OF THE DEATH** **In April 2013 Mrs Garland developed a small spot on her leg. She telephoned her doctor and was apparently prescribed antibiotics. In June 2013 she was visited at home by two doctors from the GP Practice and it was noticed that she had necrotic wounds to her right foot. She thereafter had treatment by the District Nurses. By the beginning of September her wounds were worsening and she was seen again by the GP. Two attempts were made to get her to an outpatient appointment at the hospital. Because of transport difficulties she was unable to attend either of these appointments.** **On the 12th September 2013 she was seen at home by her GP who did not examine her legs as there was no nurse to re-dress them. The GP now accepts that it would have been preferable for a District Nurse to have accompanied him on the appointment. The GP also conceded that it would have been better had a doctor visited Mrs Garland on the 21st August 2013. It has also been conceded by the Head of Service that the District Nurses did not carry out their duties correctly.** **By the time Mrs Garland was moved to the Stockport area she was extremely thin with extensive gangrenous necrotic ulceration and was in a "terrible state".** **Thereafter despite the attentive care of the medical and nursing authorities and the care and attention of her family, Mrs Garland's condition continued to worsen until her death.** **During the course of her treatment whilst she was living in the Blackpool area, opportunities were missed to provide her with the optimal level of medical and nursing care.**
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. **There was a failure by the GP practice to recognise or fully appreciate the severity of the ulceration to her legs.** 2. **There was a failure by the District Nursing service to fully appreciate and treat appropriately the necrotic ulcers from which Mrs Garland was suffering.** 3. **Despite the fact that she was considered to be in need of an outpatient appointment at Blackpool Hospital on two separate occasions, this did not take place because no-one organised transport for her to get to and from the hospital.** 4. **A home visit from the GP took place on the 12th September 2013 yet the doctor did not even examine the patient's legs. He had not taken the simple expedient of arranging for a District Nurse to be in attendance to redress the legs.** 5. **The District Nurses did not perform their duties correctly in a number of ways as conceded at the inquest by their Head of Service.**
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **13th August 2013**. 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 namely [redacted] **(daughter of the deceased),** [redacted] **(Care Manager)** [redacted] **(Clinical Nurse Manager)**. I have also sent it to **CQC** 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	**Date** **John Pollard, HM Senior Coroner** **17th June 2014**