REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Paula Head, Chief Executive Sussex Community NHS Trust Sussex Community NHS Trust Brighton General Hospital Elm Grove Brighton BN2 3EW

NHS Coastal West Sussex CCG 1 The Causeway Goring-by-Sea West Sussex BN12 6BT

1 CORONER

I am Penelope Anna Schofield, Senior Coroner, West Sussex

2 CORONER'S LEGAL POWERS

I make this report under Para 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 13th June 2014 I commenced an investigation into the death of James Bateley, born on 24th November 2014, being 88 years of age. An Inquest was opened on 13th June 2014 and was concluded on 10th March 2014

4 CIRCUMSTANCES OF THE DEATH

Mr Bateley was admitted to Worthing Hospital on 30th May 2014 as he was medically unwell. Severe pressure sores with necrosis of tissue on buttocks and scrotal area were documented. A safeguarding alert was raised due to the severity of these pressure sores. Mr Bateley died on 6th June 2014. A post mortem examination was carried out and the pathologist gave as the course of death:-

- 1a. Bronchopneumonia & Sepsis
- 1b. Necrotising Fasciitis
- 1c. Pressure Wound
- 2. Ischaemic Heart disease

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise for 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 make this report to you.

The MATTERS OF CONCERN are:-

During the evidence it became apparent that neither the nursing home, where Mr Bateley was living, nor the Community Nurses, who had been called in to assist in treating Mr Bateley's pressure sores had ready access to the necessary dressings. There was evidence given that these dressings are not readily available to nursing homes or the Community Nurses who regularly have to treat this type of ailment. The dressings have to be ordered through the GP and we were told that it could take up to 14 days for them to arrive. In Mr Bateley's case staff had to borrow and make use other resident's dressings. Sadly Mr Bateley was taken into hospital before his dressings arrived. Whilst the absence of these dressing was

unlikely to have contributed directly to Mr Bateley's death there is concern for others in the future who cannot rely on others to borrow dressing from. **ACTION SHOULD BE TAKEN** 6 In my opinion action should be taken to prevent future deaths and I believe you and your organisation, can take such action. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely 18th May 2015. I, the Coroner, may extent that period. Your response must contain details of action taken or proposed to be taken, setting out the timeline for action. Otherwise you must explain why no action is proposed. **COPIES and PUBLICATION** 8 I have sent a copy of my report to the Chief Coroner and to the following interested persons: 2. 3. Sussex Community NHS Trust Sussex Community NHS Trust 4. NHS Coastal West Sussex CCG 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 representation to me, the Coroner, at any time of your response about the release or publication of your

SIGNED:

response by the Chief Coroner

March

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