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. His Honour Judge Peter Thornton QC, HM Chief Coroner.
- 2. Mr. Mark Drakeford, Minister for Health, National Assembly for Wales.
- 3. Mrs. Allison Williams, Chief Executive, Cwm Taf University Health Board.
- **4.** General Medical Practitioner, Bryntirion Surgery, Bargoed.
- 5. Ms. Judith Paget, Chief Executive, Aneurin Bevan University Health Board.
- 6. Manager of Four Season's Healthcare Home, Bargoed.
- **7.** Son of the deceased.

1 CORONER

I am Dr. Sarah-Jane Richards, Assistant Coroner, for the Coronial area of Powys, Bridgend and Glamorgan Valleys

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 the 21st April, 2015 I commenced an investigation into the death of Mr. Arthur Cook, 78 years old. The investigation concluded at the end of the inquest on the 3rd July, 2015. The conclusion of the inquest was 'Death from a poorly managed MRSA infected wound'.

4 CIRCUMSTANCES OF THE DEATH

Mr. Arthur Cook suffered from poor circulation and was being treated by vascular surgeons for gout and necrosis of his toes leading to toe amputation. Since March 2014, he had been a patient under the care of both the Aneurin Bevin Hospital Board (ABHB) and the Cwm Taff University Health Board (CTUHB). During this period he had been admitted to the Royal Glamorgan Hospital; the Ysbyty Ystrad Fawr; and the Four Seasons Healthcare Residential Home where he was under the medical supervision of the Bryntirion Surgery, Bargoed, all of which are under the ABHB.

Mr. Cook had further periods of hospitalisation in Prince Charles Hospital which is administered by CTUHB. He was discharged from Ward 31, Ysbyty Ystrad Fawr to the Four Seasons Healthcare Residential Home on 14th January, 2015 with a chronic open wound to his right knee - an injury sustained when a patient in the Royal Glamorgan Hospital.

Whilst a resident at the Four Seasons Healthcare Residential Home, Mr. Cook developed a wound (possibly pressure ulcer) to the back of the right knee. On the 25th January 2015 the wound exudate was assessed as ++. At this time tissue viability care was sought from the ABHB and again in February 2015 but the residential home Manager was advised of the lack of availability of specialist nursing advice at that time. TVN advice was not provided until April 2015. At this time Mr. Cook was admitted to Prince Charles Hospital with an MRSA infected category 4 pressure ulcer. He failed to respond to treatment and subsequently passed away.

5 | CORONER'S CONCERNS

During the course of the Inquest, 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) Staffing levels of Tissue Viability Nurses within the Aneurin Bevan Health Board are low and to the extent that at times this service cannot be provided according to need:
- (2) The CTUHB and residential Care Home failed to maintain adequately pressure ulcer documentation and repositioning charts making more likely the progression of MRSA infected pressure ulcers and wounds failing to heal.
- (3) An apparent lack of integrated skin care within and between Health Boards and Primary healthcare services.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action in the area of prevention, diagnosis and treatment of escalating pressure ulcers by:

- Ensuring microbiology results which confirm MRSA infectivity are notified to the GP and Community nurses and Residential home staff involved in the treatment of a residential home patient even when results pertain to a patient in a different Health Board's area:
- > For the ABHB to ensure staffing levels of tissue viability nurses are such that vulnerable patients (including the elderly who have limited mobility) have access to specialist services to inhibit the escalation of pressure ulcers to the point they are causative of death through infection; and
- GPs to be proactive in checking their elderly residential patients are receiving expert nursing input when required.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm on Friday 16th October, 2015. 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 His Honour Judge Peter Thornton QC the Chief Coroner; Mr. Mark Drakeford, Minister of Health, National Assembly for Wales; Allison Williams, Chief Executive, Cwm Taf University Health Board; Primary Clinical Director Aneurin Bevan University Health Board, Division of Primary Care & Networks; Roberts, General Medical Practitioner Bryntirion Surgery, Bargoed; Manager of Four Season's Healthcare Home, Bargoed; and Roberts, Son 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 **DATED**: 27th July 2015

SIGNED:

HM Assistant Coroner Dr. SJ Richards