ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Birmingham and Solihull Mental Health Trust
2. Right Honourable Jeremy Hunt MP - Secretary of State for Health
3. NHS England</td></tr>
<tr><td>1</td><td>CORONER

I am Louise Hunt, Senior Coroner, for the coroner area of Birmingham and Solihull</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On 9th October 2014 I commenced an investigation into the death of Doreen England. The investigation concluded at the end of the inquest on 21st July 2015. The conclusion of the inquest was a narrative:

The deceased died from an infected grade 4 pressure sore which developed during her admission from 20/7/14. There was a gross failure to prepare and put a care plan in place to monitor and prevent pressure sore formation following a waterlow score of 17 indicating high risk on 20/7/14. There was an overall lack of knowledge on the ward of how pressure sores formed and how they could be prevented. Her death was contributed to by neglect.</td></tr>
<tr><td>4</td><td>CIRCUMSTANCES OF THE DEATH

The deceased was an 81 year old lady who suffered from vascular dementia. Her family were unable to care for her at home due to deterioration in her condition. She was unsettled and screaming out. She was initially admitted to an EMI residential home who were unable to cater for her needs. She went to A&E at Good hope hospital on 19/07/14. They arranged a mental health assessment which resulted in her being admitted to Rosemary Suite at the Juniper Centre (part of Birmingham and Solihull Mental Health Trust) on 20/7/14. On admission a waterlow score was undertaken which confirmed a result of 17 indicating she was at high risk of pressure sore formation. Despite this risk no care plan was prepared, and no care provided to prevent pressure sores occurring. On 23/7/14 blood test results revealed a raised white cell count and CRP indicating possible infection – these results were not followed up or repeated. On 24/7/14 her sacrum was noted to be red. On 25/7/14 a further waterlow score was undertaken which showed a result of19. A care plan was prepared including a 2 hourly turning chart but this was not commenced. By the evening on 27/7/14 her sacrum was described as having a very bad sore and a 2 hourly turning chart was put in place. From 28/7/14 she was nursed in bed to relieve pressure on her sacrum. On 29/7/14 she became systematically unwell and was prescribed antibiotics. Her condition deteriorated resulting in her admission to QEHB on 30/7/14 when a grade 3 pressure sore was diagnosed. Bu 08/08/14 she developed osteomyletis of the sacral bone and a chest</td></tr>
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	infection. The sore was graded as 4 by 11/8/14. Towards the end of August there was some improvement in her condition but she deteriorated again on 02/09/14. She deteriorated further on 17/9/14 and remained unwell until her death on 30/9/14.
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) Despite a waterlow score on admission confirming she was at high risk of pressure sore formation no care plan was prepared. Staff at the inquest confirmed they had a lack of knowledge about pressure sore formation and how to prevent pressure sores occurring. Staff working on mental health wards dealing with elderly patients must have a clear understanding of basic medical care in particular how pressure sores occur and what steps are required to address those at high risk. (2) Since these events staff confirmed at the inquest that they had still not had training on pressure sore formation and prevention. (3) Rosemary suite had no leadership at the time. Staff were completing paperwork but not then actioning risks that were identified. The consultant and ward doctor were on leave at the same time and medical cover was only available from doctors off site who had to be requested to attend. The ward and trust need to ensure there is clear leadership on the ward with adequate medical cover. (4) Registered Mental Health Nurses at the inquest confirmed their RMN training had not covered the subject of pressure sores in any detail and they felt they had inadequate awareness and knowledge. This is a subject that should be covered in the RMN curriculum.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisations 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 21 September 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 the Chief Coroner, the family, [redacted] from West Midlands Police and the clinical commissioning group. 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	**23rd July 2015** [redacted]