

PS Cooper Senior Coroner for South Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
71	THIS REPORT IS BEING SENT TO: Lincolnshire Community Health Service NHS Trust
1	CORONER
	I am PS Cooper, Senior Coroner for South Lincolnshire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On 09/07/2015 I commenced an investigation into the death of Ruth Milne, 83. The investigation concluded at the end of the inquest on 11 May 2017. The conclusion of the inquest was Natural causes. The deceased died in the Pilgrim Hospital, Fishtoft, Boston on 10/6/2015. Safeguarding have now identified that continuity of patient care by various nurses attending and the lack of expertise in the weeks immediately preceding her death did not assist. The Inquest focused on the standard of care with family members and other medical staff referring to strong unpleasant odours since January 2015 to death and live maggots being seen under her skin by the hospital on the day of her admission that went unnoticed by the GP/nurses previously.
4	CIRCUMSTANCES OF THE DEATH Deceased admitted at 1205hrs on 09/06/2015 with severe sepsis due to both legs skin tissues (legs) being infectious. Her multi organ failure decompensate in septic shock. She received antibiotics IV Cefuroxime and IV Metronidazole and IV fluids without increasing BP. She died within 24hrs of admission. Death confirmed at 0025hrs. Cause of death was due to 1a Multi-organ failure 1b Septic shock 1c Leg abscess 2 CCF, CKD.
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) The lack of continuity and the appropriateness of the medical staff despatched by the GP's at Hawthorn Medical Practice, Skegness. The Safeguarding report by Johnstone Head of Safeguarding dated November 2015 identified this. (2) Lincolnshire Police also investigated for an act of criminality. (3) I really need to know if all the Action Plan, Monitoring and recommendations' (on page 11 & 12) of the safeguarding report have now been implemented and if not why not.

6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you Lincolnshire Register Office 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 1 August 2017. 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 Lincolnshire Community Health Service NHS Trust. I have also sent it to 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	Signature Senior Coroner for South Lincolnshire