IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of June Evelyn Evans
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **Suzanne Rankin Chief Executive of St Peter's Hospital, Guildford Road Chertsey, Surrey, KT16 0PZ**
1	**CORONER** Caroline Topping HM Assistant Coroner for the County of Surrey
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** An inquest into the death of Mrs June Evelyn Evans was opened on 11th July 2016 and resumed on 28th September 2017. It was concluded on 5th October 2017. I concluded that Mrs June Evelyn Evans died on the 1st July 2016 at St Peter's Hospital, Guildford Road, Chertsey, Surrey and that the medical cause of her death was; 1a Sepsis 1b Sacral Ulceration I concluded with natural causes contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Evans was admitted to St Peter's Hospital on the 3rd June 2016. The presenting complaint was of diarrhoea. A Waterlow assessment score was recorded on admission of 23. This meant that Mrs Evans was at high risk of developing pressure sores. The Ashford and St Peter's Trust's Policy on the Prevention of Pressure Sores was not adhered to. Mrs Evans was not turned with sufficient frequency, her wounds were not observed as they should have been and she was not nursed on a pressure relieving mattress. On the 8th June 2016 an agency nurse noted in the nursing records on a body map that Mrs Evans had developed a grade 3 hospital acquired pressure sore. The Trust policy required an immediate referral be made to the tissue viability nurse. Despite the pressure sore continuing to be recorded on the 10th, 11th and 12th June 2016 a referral to the tissue viability nurse was not made until the 13th June 2016. Mrs Evans was seen on ward rounds daily between the 8th and 15th June 2016. During that period Mrs Evan's inflammatory markers were rising and the treating doctors were trying to establish the source of the infection. Mrs Evans was started on antibiotics on the 12th June 2016. It was not until the 15th June 2016 that the treating doctors record the presence of the pressure sore and query whether this could be the source of the

	infection. Mrs Evans was assessed by dieticians on a number of occasions during her admission to hospital and advice was given as to her nutritional requirements. A sufficient intake of nutrition is required to combat sepsis and repair damaged skin. Mrs Evans was not fed in accordance with the dietician's advice and did not receive adequate nutrition. The pressure sore deteriorated and became infected. At post mortem the pressure sore was found to measure 11cm by 14 cm and to be the full thickness of the skin. In addition the ulcer ran under the skin into the tissue for a further 5cm. Mrs Evans died of sepsis as the infection in the pressure sore on the 1st July 2016.
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 could 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 evidence showed that failure to refer the hospital acquired grade 3 pressure sore to the tissue viability nurse on the 8th June 2016 was as a result of the employment of an agency nurse who was unfamiliar with the Trust's Policy on the Prevention of Pressure Sores. If the referral had been made to the tissue viability nurse on the 8th June 2016 it would not have deteriorated as it did. 2. The treating clinicians were unaware that Mrs Evans had developed a grade 3 hospital acquired pressure sore, noted on the 8th June 2016, until the 15th June 2016. They were therefore unable to make informed decisions as to her treatment, including the antibiotic regime to be followed. 3. Dietician's advice in respect of the quantity of nutrition required by Mrs Evans was not implemented by the nursing staff. Naso- gastric feeding was advised by both the treating doctor and the dietician on the 14th June 2016. This advice was not followed and there was no evidence of why this did not occur. Mrs Evans was not provided with adequate nutrition. 4. Mrs Evans was nursed on 3 wards from the 4th to the 30th June. The wards were not staffed according to the levels identified as correct staffing levels by the hospital which detracted from the ability of the nursing staff to undertake the tasks required to protect Mrs Evans from pressure sores and ensure she received adequate nourishment. 5.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 14th December 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; [redacted]. 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	**Signed:** **Caroline Topping** **Dated this 19th October 2017.**