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

The Inquest Touching the Death of Ronald Arthur Farrington
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • [redacted], **Director Saffronland Homes Ltd, Maple House, 121b, Winchester Road, Chandlers Ford, Hampshire, SO53 2DR** • **Sir David Behans CBE Chief Executive Care Quality Commission** • **Sarah Billiald, Chief Executive, Surrey First Community Health Care 2nd Floor, Forum House, 41-51 Brighton Road, Redhill, Surrey RH1 6YS** • [redacted], **Surrey County Council Acting Chief Executive,**
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 Mr Ronald Arthur Farrington was opened on 5th May 2017 and resumed on 2nd November 2017.It was concluded on 17th November 2017. I concluded that Mr Farrington died on the 21st June 2016 at East Surrey Hospital, 1 Canada Avenue, Redhill, Surrey and that the medical cause of his death was; 1a Sepsis 1b Pressure ulcer of the sacrum and pneumonia II Neuro-degenerative disease, dementia and cerebrovascular disease. I found as follows: Ronald Arthur Farrington became resident at the Nuffield Care Centre in August 2014. He was at high risk of developing pressure sores and developed a sacral pressure sore by January 2015.Tissue viability nurses gave advice to the Nuffield Care Centre from January 2015 until October 2015. Some of their advice was not followed, in particular he was not turned on a 2 hourly basis as required from September 2015. He developed further pressure sores. No further advice was sought from the tissue viability nurses until a referral was made on the 1st June 2016. By then he had a Grade 4 sacral pressure sore which had become infected. No medical treatment was sought in respect of the infection from his general practitioner. The tissue viability nurse was unavailable until the 29th June and was not alerted to any urgency. He was admitted to East Surrey Hospital on the 15th June 2016 suffering from sepsis caused by the infection in the sacral pressure sore. He developed pneumonia in hospital, this contributed to the sepsis. Despite appropriate treatment he died from sepsis in hospital on the 21st June 2016.

	The conclusion was: Natural causes contributed to be neglect**.**
4	**CIRCUMSTANCES OF THE DEATH** Mr Farrington was admitted to the Nuffield Care Centre, Haigh Crescent, Redhill, Surrey, RH1 6RA, a registered nursing home, on the 6th August 2014.He was suffering from Dementia and Parkinson's Disease. He became bedbound. In January 2015 a referral was made to First Community Care who provide the tissue viability nurse service in Surrey. The advice given by the tissue viability nurses was incorporated into his care plan in May 2015 which included repositioning every 4 hours. He was discharged from the tissue viability nurse service in July 2015. In September 2015 he was re-referred to the service with a grade 4 sacral sore. Concerns were raised by the tissue viability nurse that her earlier advice had not been followed. Further advice was given including that Mr Farrington be turned every 2 hours. This advice was not recorded in the care plan. In the absence of any further requests for advice from Nuffield Care Centre Mr Farrington was then discharged from that service. Nuffield Care Centre made 2 referrals in 2016 to the Care Quality Commission (the CQC) in respect of Mr Farrington's sacral pressure sores. On each occasion the CQC accepted the written assurance of the registered manager that Nuffield Care Home was following the advice of the tissue viability nurses. No independent investigation was conducted, neither First Community Care nor the family were asked to provide any information. The information provided by the registered manager was incorrect. In November 2015 the CQC undertook an inspection of Nuffield Care Centre and the inspectors were told there was ongoing tissue viability nurse involvement with Mr Farrington which there was not. Mr Farrington was not being turned on a 2 hourly or even 4 hourly basis. On 16th March 2016 First Community Care sent a letter advising Nuffield Community Care that they now only retained one tissue viability nurse and in her absence on annual leave for 4 weeks they should contact the patient's general practitioner with any issues requiring tissue viability advice. [redacted], Mr Farrington's doctor, said this would not be within his expertise. On the 1st June 2016 staff at Nuffield Care Centre recorded that Mr Farrington's wound looked infected and was not improving. A further referral was made to First Community Care on the 1st June 2016. This went unanswered until the 15th June 2016 because the tissue viability nurse was again on annual leave. Mr Farrington's care plan required any sign of infection to be referred to his General Practitioner. This was not reported to [redacted]. Mr Farrington developed sepsis from the infected pressure sore. He was admitted to East Surrey Hospital, 1 Canada Avenue, Haigh Crescent, Redhill, Surrey, RH1 6RA on the 15th June 2016. Despite appropriate treatment in hospital Mr Farrington died on the 21st June 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. Nuffield Care Centre: a.) Failed to incorporate all the advice given by the tissue viability nurses in Mr Farrington's care plans. b.) Failed to keep accurate records. c.) Informed the CQC that the tissue viability nurses were still involved with Mr Farrington when they weren't. d.) Failed to follow the advice of the tissue viability nurses as to turning and how to dress Mr Farrington's sores e.) Failed to refer Mr Farrington to his General Practitioner when he developed an infection in the sacral pressure sore on the 1st June 2016. 2. Only one tissue viability nurse was employed by First Community Care from March 2016 onwards. They were on annual leave for 6 weeks between the 18th

	March and the 15th June 2016. This was not an adequate level service. 3. The CQC did not obtain independent evidence about Mr Farrington's care having received 2 notifications that he had developed pressure sores. 4. Mr Farrington's family who visited him on a very regular basis and could have provided information about his care were not made aware that he had developed pressure sores, nor that the CQC were conducting any enquiries. 5. A large scale review has been convened as a result of the safeguarding alert raised by East Surrey Hospital. It is now being conducted by Surrey Adult Safeguarding. As at the date of the resumed Inquest no adequate s42 report has been written. The family have not been invited to take part in the review. No adequate enquiry has been made.
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 16th February 2018. 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 following: 1. The Chief Coroner 2. [redacted] 3. [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 22nd December 2017.**