REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Dr Karen Stone, Medical Director, Mid Yorkshire Hospitals NHS Trust, Aberford Road, Wakefield, WF1 4DG**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner for the coroner area of West Yorkshire (Eastern)
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 5 January 2018 I commenced an investigation into the death of Eileen Cooke, aged 80. The investigation concluded at the end of the inquest on 23 October 2018. The conclusion of the inquest was a **Narrative** conclusion which recorded her complex medical and nursing needs and noting that she was discharged from hospital on 7 November 2018 to a nursing home despite ongoing unmet medical needs. The cause of her death was 1a) Pneumonia, 1b) Dementia and 2) Ankle fracture with pressure ulcer secondary to Contractures and Osteoporosis.
4	**CIRCUMSTANCES OF THE DEATH** Eileen Cooke aged 80 died in Pinderfields Hospital on 21 December 2017. She was the epitome of a vulnerable elderly lady who had been bed bound for some years and was frail. She had dementia and gross contractures of her left leg as a result of previous leg fractures, exacerbated still further by a fracture of her left ankle in September 2017. In consequence, her left foot lay permanently in a distorted position under her bottom. She was thus susceptible to pressure sores. The management of her condition presented complex problems to the clinicians and nurses involved in her care.
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. Consideration was given to an amputation of her left leg at her groin but it was recognised this would entail significant risks for a frail lady aged 80 with a range of co-morbidities. A 'best interests' multi-disciplinary meeting was mooted but never organised. 2. She was nevertheless deemed medically fit to be discharged from hospital on 7 November 2017 despite the progressive deterioration of the soft tissues around her left ankle fracture site and painful ulceration between her thighs. At this point in time the question of amputation or an alternative management plan were unresolved. The discharge letter was produced by a 'Trust Grade Doctor-Career Grade Level' unknown to the family. 3. The family were not involved in her discharge from hospital at all. It was arranged in haste. Inadequate preparatory work had been done to establish how her wound dressing could be carried out and the pain control needed whilst this was done. No consideration was given to the skills required to achieve this, or the wisdom of involving a tissue viability nurse. 4. Evidence taken from healthcare professionals at the Inquest indicated that the

	7.11.17 discharge was an error of judgement. It effectively passed an unresolved problem to a nursing home. 5. A 'best interests' meeting was required to assess her needs and formulate a management plan. This should have involved the orthopaedic surgeon, the vascular surgeon, nurses, a physio-therapist, a care of the elderly physician, a palliative care specialist, the general practitioner and the family. In the event no such meeting was arranged. It appeared difficult for senior clinicians to get hold of each other. Even if the issues proved unsolvable the family would have at least understood the positon and could brace themselves for a period of palliative care, rather than being left in the dark. 6. After about three weeks in the nursing home, during which period her condition deteriorated, Mrs Cooke was re-admitted to Pinderfields Hospital after the GP and a local MP became involved. 7. The Inquest heard further evidence that hastily arranged discharges from Pinderfields Hospital are not uncommon and as a result patients can be sent home without an adequate supply of prescribed medication (for example, because the hospital pharmacy has closed by the time the discharge is organised). 8. Having heard the evidence relating to the treatment received by this vulnerable elderly lady, I am concerned that the safety of others may be put at risk by precipitously arranged discharges.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 December 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 Chief Coroner and to the following Interested Persons [redacted] (daughter), [redacted], Registered Manager, Priory Gardens Care Home, Ladybalk Lane, Pontefract, WF8 1JQ, HC-One Limited, Southgate House, Archer Street, Darlington, DL3 6AH. I have also sent it to [redacted] General Practitioner, The Surgery, Stuart Road, Pontefract, WF8 4PQ. Rt Hon Yvette Cooper MP, 1 York Street, Castleford, WF10 1RB and the Care Quality Commission HQ in Bury 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	Kevin McLoughlin **25 October 2018** **Kevin McLoughlin**