IAN S SMITH
LL.B, Hon DUniv
HER MAJESTY'S CORONER

for the
Stoke-on-Trent and North Staffordshire
Coroner's Area

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, **Midlands Partnership NHS Foundation Trust**
1	**CORONER** I am Margaret J Jones, HM Assistant Coroner for **Stoke-on-Trent & North Staffordshire**
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 30/10/2017 I commenced an investigation into the death of Sheila Graham. The investigation concluded at the end of the inquest on 15th November 2018. The conclusion of the inquest was that the deceased died from a combination of natural causes, an accident and the effects of necessary antibiotic drug therapy. The deceased was 79 years of age. She was a smoker and obese. Her medical history included hypertension, chronic obstructive pulmonary disease, hip replacement, cellulitis and heart disease with a pace maker fitted. She had a history of about 12 months of vomiting which she put down to her Digoxin medication. She had been in hospital a few months earlier and had been treated with antibiotics for a chest infection. On the 7th July 2017 she suffered a fall at home and was admitted to the Royal Stoke University Hospital, Stoke-on-Trent. A complicated fracture of the left ankle was diagnosed. Due to her co-morbidities she was not suitable for surgery and a cast was applied. She was transferred to Haywood Hospital, Stoke-on-Trent where on admission there was evidence of abnormal blood results indicating infection and clinical signs of cellulitis. She was treated with antibiotics targeting that particular infection. She developed clostridium difficile. The fracture failed to heal and this together with her existing co-morbidities resulted in prolonged immobilisation and hospitalisation. Progression with physiotherapy was minimal. She required nursing in isolation and this affected her mental and general wellbeing. Nausea and vomiting were ongoing problems caused by constipation. On the 12th July 2017 she declined further investigations. She was also observed putting her fingers down her throat which induced blood stained vomit. She was referred to a dietician, mental health services and a nutritional chart was commenced following a multi-disciplinary meeting arranged at the request of the family. She had not been assessed as being nutritionally at risk however recording of nutritional information was inadequate. On the 18th September 2017 she developed coffee ground vomiting. This occurred again on the 19th and she was transferred back to the Royal Stoke University Hospital. She was dehydrated and was treated for an upper gastrointestinal bleed. She did not recover and died there at 11.55pm on the 13th October 2017.
4	**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) At the inquest it was evident that the deceased had suffered with clostridium difficile diarrhoea. It was accepted by the patient and the family that she needed to be nursed in a single room. However in her case it was for a very prolonged period. The social isolation had a very significant impact on her health and well-being and was a factor in her failure to recover. No policy appears to be in place for referral to mental health services in such circumstances. Referral in this case was prompted by the family. (2) There was evidence that meals were delivered by an independent company called Sodex. The family frequently observed this company giving out and collecting meal trays. Despite this medical records appeared to have been completed daily by nursing and health care staff recording adequate nutrition. Given this situation how is it possible to reconcile the nursing records with the practice of the catering team distributing and collecting meal trays? (3) The deceased lost weight. There was no referral to a dietician until prompted by the family.
5	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation has the power to take such action.
6	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely Thursday 31st January 2019. 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.
7	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:- 1. [redacted] daughter of the deceased. 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.
8	16/11/2018 Signature Margaret J Jones, HM Assistant Coroner **Stoke-on-Trent & North Staffordshire**