REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Ms Karen James, Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust, Tameside General Hospital, Ashton-under-Lyne, OL6 9RW

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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

INVESTIGATION and INQUEST

On 1st November 2018, I opened an inquest into the death of Mellin Beard who died on 16th October 2018 at Tameside General Hospital, Ashton-under-Lyne, at the age of 91 years. The investigation concluded with an inquest which I heard on 24th April 2019 and which concluded with a Narrative Conclusion to the effect that Mr Beard died as a consequence of left ventricular failure due to ischaemic and hypertensive heart disease. His death was contributed to by serious and complex underlying health problems including infected pressure sores.

CIRCUMSTANCES OF THE DEATH

Mr Beard had a complex medical history which included hypertension, osteoarthritis and carotid artery stenosis. In early 2018, his mobility deteriorated with him also experiencing altered sensation in his arms in February, leading to his admission to Tameside General Hospital. Investigations confirmed he had developed spinal cord compression.

Mr Beard was treated conservatively and discharged home with significantly reduced mobility. As a consequence of this combined with poor nutrition and loss of trunk control, Mr Beard developed a pressure sore on his left heel and an area of redness on his right heel. Mr Beard received treatment for his wounds by the District Nurses and they improved. Mr Beard was readmitted to hospital on 31st July 2018 having become unwell, and was treated for acute coronary syndrome.

By the time he was discharged from hospital, Mr Beard had developed a pressure sore on his right heel, and his left heel pressure sore had still not resolved. When Mr Beard was discharged home, he received further care from the District Nurses and the High Risk Foot Team. It was quickly appreciated Mr Beard was reaching the end of his life and he was transferred to Parkhill Nursing Home.

Despite some initial improvement of his pressure sores, by 15th October 2018, it was recognised these were deteriorating despite all recommended care measures being followed. Mr Beard died the following day.

A post mortem examination concluded that Mr Beard died as a consequence of:

1a) Left Ventricular Failure;

b) Ischaemic and Hypertensive Heart Disease;

2) Spinal Cord Compression, Pseudogout, Urinary Sepsis, Infected Pressure Sores

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. A member of the Trust's community nursing team gave evidence to the effect that it was 'common' not to receive timely referrals in respect of patients who were discharged from hospital and required community nursing services. Whilst it was apparent from the evidence before the court as a whole that this concern does not relate solely to patients who have been receiving in-patient care at Tameside General Hospital, and that some improvements have been made with the introduction of an e-discharge system, it is a matter of particular concern that this problem continues to subsist at the Trust in particular due to the integrated care model as between acute and community services the organisation purports to espouse;

2. The Ward Manager of Ward 31 confirmed in her evidence that, at the time of the care provided to Mr Beard, there was only one permanent substantive registered nurse working on the ward, with the vast majority of shifts being fulfilled by agency workers;

   Whilst the Ward Manager gave evidence of significant improvements to recruitment and retention of nursing staff on the ward, and of additional actions her and her team have introduced to promote consistency amongst agency staff, it is a matter of concern that there is still significant reliance on agency nurses (with the financial and continuity of care implications which can arise from that) within the Trust.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **12th July 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of Mr Beard's family.

I have sent a copy of my report to the Care Quality Commission 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.

Dated: 17th May 2019.

Signature: Chris Morris HM Area Coroner, Manchester South.