REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Lancashire Teaching Hospitals NHS Foundation Trust** **2. The Chief Executive, Blackpool Teaching Hospital NHS Foundation Trust** **3. The Manager, Croft House Rest Home, Freckleton, Lancashire.**
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
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 18th February 2013 an investigation commenced into the death of Freda Virginia Owens aged 93 years. The investigation concluded at the end of the inquest heard on 18th and 19th November 2014. The record of the inquest confirmed as follows: The Medical cause of death was 1a Bronchopneumonia 1b Infected necrotic pressure ulcer left hip and scalds / burns to buttock and perineum The conclusion of the Coroner as to the death was a Narrative conclusion as follows: **On 2nd November 2012, Freda Virginia Owens was placed on a commode in her room at the care home where she resided. Approximately one inch of warm water had been placed into the commode in the hope that the resulting steam would ease the Deceased's constipation problem. This unintentionally resulted in burns and scalding. Following treatment these injuries had begun to heal but when examined on 21st November 2012 – an examination which did not include an assessment of the left hip area – the Deceased was noted to have deteriorated and she was hospitalised on 23rd November 2012. It was not until 24th December 2012 that an injury to the left hip area was recognised as a pressure ulcer. There was a delay in**

	treatment which could have affected the outcome.
4	**CIRCUMSTANCES OF THE DEATH** See the contents of section 3 above. During the course of the inquest evidence was heard as follows: The Deceased had been assessed as being at high risk of developing pressure sores. Following her suffering burns / scalds on 2nd November 2012, District Nurse personnel were not made aware that the Deceased was incontinent of urine or the extent of her restricted mobility. That although a District Nurse had assessed the Deceased on 21st November 2012 and had decided not to examine the Deceased's left side because as she explained she did not want to cause her any additional pain, this was not communicated on to medical staff at the Royal Preston Hospital when she was hospitalised two days later. At Royal Preston Hospital photographs were taken of the Deceased's injuries on the 23rd November 2012 including her left hip area. There was initially a focus upon treating concerns raised about her heart and kidney function. On 27th November 2012 staff from the plastic surgery team at the hospital reviewed Mrs Owens but in the context of her injuries being burns / scalds rather than pressure areas. An expert witness gave evidence that the plastic surgeons were dealing with the "aftermath" of the burns incident, but that the deep damage [regarding the pressure area] went unnoticed when in retrospect "all clues were there". It was not until 3rd December 2012 when a Tissue Viability Nurse examined Mrs. Owens but the Nurse confirmed that the history the hospital staff had been given as regards events concerning the use of the commode on the 2nd November and subsequently regarding the care given to her was limited. She acknowledged that this had contributed to an assumption being made that the injury to her left hip was not a pressure sore area but another of the burns / scalds inflicted on the 2nd November 2012. The expert witness felt that the matter was irretrievable 13th November 2012 onwards. In due course on 24th December 2012 that Tissue Viability Nurse recognised the left hip area as a pressure ulcer.
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. – At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Trust by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009. I now write to the two Hospital Trusts and to the Croft House Rest Home to confirm that in my view action should be taken because there is a concern about the quality of the gathering and exchange of information between the various medical professionals involved in Mrs. Owens's care for the following reasons:

	1. A District Nurse was unaware of potentially important information as regards the Patient including how restricted her movement was. 2. Having considered all of the oral evidence in court and the clinical records, the amount and quality of the information provided to the hospital is limited and this had an impact upon later decisions taken and not least by the Tissue Viability Nurse once she was involved. 3. Although the District Nurse explained why she did not examine the Deceased's left hip area on 21st November 2012, the Nurse in my view ought to have examined that area given the Patient was viewed as being at high risk of developing pressure areas. Such examination may have prompted her, given her professional experience, to recognise a pressure area as distinct from a burn / scald and that information may then have been communicated on to hospital staff who would have then most likely involved the Tissue Viability Nurse more quickly reducing the chances of an incorrect assumption being made that the hip area was problematic as a result of a pressure area and not due to burns inflicted on 2nd November 2012. However, having chosen not to do so this was not then communicated to other medical professionals involved in her care for them to assess. 4. That following arrival and assessment at the Royal Preston Hospital, that there was a lack of communication between the clinical team and the plastic surgery team, which appears to have contributed to the fact that it was not until 3rd December 2012 when the Tissue Viability Nurse became involved. These issues as regards the gathering and exchange of information as regards this Patient raise concerns that an incorrect assumption – such as the one made that Mrs Owens hip area was damaged due to the incident involving the commode on 2nd November 2012 - may arise in a future case and with fatal consequences if such an incorrect assumption were not to be recognised early enough to positively affect a Patient's outcome. I would therefore be obliged if the two Hospital Trusts and the Manager of the Croft House Rest Home would write to me in due course to confirm what steps if any the Hospital Trusts propose to take to address this issue.
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 24th January 2015. 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 The family of Freda Virginia Owens The Coroners Society 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	*A.A.Wilson* **Alan Wilson** **Senior Coroner for the area of Blackpool & Fylde** **Dated: 27th November 2014**