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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive Officer Medway Community Healthcare**
1	**CORONER** I am Sonia Hayes Assistant Coroner for **Mid Kent and Medway**
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 24th April 2019 I commenced an investigation into the death of Dorothy June MACEY. The investigation concluded at the end of the inquest 6th November 2019. The conclusion of the inquest was Died at Medway Maritime Hospital on 7th October 2018 of gangrene of her lower left leg. Colonised in post-traumatic lesions from an accident on 27th May. She was discharged home on 15th August with a care package and specialist leg dressing from district nurses. Antibiotic treatment on 13th September was not received and this information was not escalated to the G.P on 20th or 24th September. She was admitted to hospital on 28th September and treated for sepsis. On 1st October gangrene was noted and her leg was not salvageable, and she was not clinically fit for amputation. She was placed on palliative care on 3rd October. She died from a complication of a previous injury to her legs. The treatment strategy was not adhered to. It may have prolonged her life but may not have saved it. 1a **Gangrene (left lower leg)** b c II
4	**CIRCUMSTANCES OF THE DEATH** She had a fall in May and her legs went through a glass door and she underwent a period of hospital admission and rehabilitation. She was discharged home on 15th August with a domiciliary care package was under the care of district nurses providing specialist dressings. Carers escalated concerns about pain and levels of exudate in her legs on a number of occasions. The GP made home visits on 22nd August and 7th September and prescribed antibiotics on the home visit on 13th September with the district nurse present. An out of hours nurse visit was made on 16th September and no issue was raised about delay in the antibiotic regime. Carers raised further concerns and the district nurse visited on 20th September as it was established the antibiotics had not been received although the pharmacy had the prescription. The nurse contacted the pharmacist who had not dispensed the prescription. The GP was not informed about the delay in commencing the treatment regime. Her condition was not improving and a request was made by the district nurse to the GP surgery for antibiotics on 24th September. Information was not shared with or advice sought from the GP surgery about the delay in the treatment regime. A final nurse visit took place on 26th September. A further visit was due to take place on 28th September but was scheduled for 1st October. The clinical practitioner form the GP surgery admitted her to hospital as an emergency on 28th September for sepsis.

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) Protocol required district nurses to photograph the leg wounds to assist in the assessment and this was not done on any of the visits. I heard evidence that photographs on the patient electronic record cannot be accessed remotely on home visits limiting the shared information that should be available to conduct an assessment. (2) District nurses did not share information with the GP when it was established that there had been a delay in the prescribed antibiotic treatment regime, and this was not escalated within the team. (3) Incomplete recording- The district nurse electronic care and treatment records on iNurse were: a) very brief and did not contain information necessary to have a comprehensive assessment or understanding of deterioration or improvement in her condition b) difficult to access remotely and showed limited information, therefore the previous nurse attendance could not be seen on particular visits. Evidence was that the record was not accessed prior to the visit on 24th September and the delay in the treatment regime was not understood when antibiotics were requested on that day. (4) A sepsis pathway check was completed on 20th September. This was not completed when antibiotics were requested on 24th September. There is a concern that developing sepsis may be missed in a deteriorating patient. (5) There was no updated care plan in place for her leg dressings. District nurse support staff changed the type of leg dressings without approval of the qualified nurses, evidence was heard that this should not be done without discussion. (6) Medication administration charts completed by carers were incomplete. The antibiotic administration was not checked despite previous issues with the delay in the treatment regime becoming known to district nurses on 20th September. This record was shared with or escalated to the GP for advice when there was a lack of improvement in her condition. (7) A visit required for 28th September was incorrectly scheduled for 1st October and was not picked up within the Missed Visit protocol in place.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 8th January 2020. 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, GP Surgery, Here to Care. 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	13th November 2019 Signature: S. M. Hayes Sonia Hayes Assistant Coroner **Mid Kent and Medway**