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. **[redacted], Central London Community Healthcare NHS Trust** 2. **Andrew Ridley, Chief Executive, Central London Community Healthcare NHS Trust**
1	**CORONER** I am Jacqueline Devonish, assistant ccroner, for the coroner area of South London
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 28 November 2019 I commenced an investigation into the death of Anita Loi, 76. The investigation concluded at the end of the inquest on 20 February 2020. The conclusion of the inquest was she died as a result of sepsis due to a leg ulcer and bronchopneumonia. A narrative conclusion was formed due to the complexity of her health and her contribution to the development and lack of care of a leg following a burn injury which developed into an infected ulcer.
4	**CIRCUMSTANCES OF THE DEATH** Anita Loi had suffered with Type 1 Diabetes for 60 years. She infrequently left the house where she lived with her two sons. In April 2019 Anita Loi reportedly burnt her left leg with hot oil when in her kitchen. This injury was nursed at home by herself and her son until 7 May when the GP was asked to visit. By this time she had become couch bound, unable take care of her personal care adequately. Cellulitis was diagnosed and a course of Flucloxacillin prescribed. There was no discharge from the burn wound but a swab was taken and a referral made by telephone to the Tissue Viability Nurse, followed up by a written referral. In view of the diabetes history the referral was accepted. The GP arranged an appointment with the Diabetes Nurse at the surgery for 16 May but this was cancelled by Anita Loi's son, at her request. On 17 May the GP's referral to the Tissue Viability Nurse Team was rejected on the grounds that Doppler Test results had not been sent. The GP therefore made a referral to the District Nurse for Doppler Tests on 31 May. On 3 June the District Nurse rejected the referral stating that it was deemed inappropriate. The GP was offered no explanation. Anita Loi's son contacted the District Nurse Team and was told that there would b a visit. In the meantime, the GP arranged another appointment with the Diabetes Nurse at the surgery for10 June but this too was cancelled by Anita Loi's son, as she was not mobile enough to attend. The GP visited on the 30 June and found the wound with odorous discharge with sloughing of the skin. Further antibiotics were prescribed and another referral made to both the District and Tissue Viability Nurses for review and management of the leg wound.

	On 1 July 2019 Anita Loi's daughter visited her mother finding her with her eyes open but motionless and unresponsive. An ambulance was called. Anita Loi was found to be in cardiac arrest. There was a return of spontaneous circulation and she was transported to hospital where she sadly passed away despite life-saving interventions.
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 could 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) The Tissue Viability Nurse and District Nurses are a part of the same community team but no steps had been taken to attend to the management of Anita Loi's leg wound despite repeated referrals by the GP and a call to the community team by the family. (2) On 11 December 2019 the GP invited the District Nurses Team and Tissue Viability Nurses Team to attend a meeting at the surgery with the practice clinicians to review unexpected deaths and to discuss this case. Neither team attended the meeting and to date have not engaged with the GP in relation to this death despite a chasing letter. (3) Whether there are appropriate policies, procedures, protocols in place for the referral of patients to the service, and the response to such referrals
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 April 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 Person [redacted]. I have also sent it to [redacted], GP, 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	**21 February 2020** Jacqueline Devonish