REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive Croydon Health Services NHS Trust
1	**CORONER** I am Jonathan Landau, assistant coroner 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 30 March 2020 an investigation was commenced into the death of John Willis Humphries. The investigation concluded at the end of the inquest on 5 August 2020. The conclusion of theinquest was: "Mr Humphries died from fluid on the lungs and a lung infection caused by a range of conditions including an infection caused by catheterisation in the context of diminishing reserves to which pressure sores contributed."
4	**CIRCUMSTANCES OF THE DEATH** Mr John Willis Humphries was admitted to Croydon University Hospital on 7 January 2020 from a nursing home with a two-day history of abdominal pain. Whilst in the Emergency Department, he developed the start of pressure sores. He was admitted to Fairfield 1 Ward the following day. He was assessed as being at risk of pressure sores and the plan included repositioning at 2-hourly intervals. Mr Humphries was on occasion resistant to turns. The staff did not seek advice from external professionals or from the nursing home as to how to manage that behaviour. As a result, the pressure sores deteriorated significantly during his stay in hospital. The pressure sores contributed to his lowering reserves. Whilst in hospital, he was catheterised to monitor his urine output though a decision was taken by a doctor for him to be catheterised permanently as this was thought to be a more humane way of dealing with his incontinence and immobility than incontinence pads. Mr Humphries was discharged back to the nursing home on 15 January 2020 but deteriorated and was readmitted to hospital on 15 February 2020. He developed recurrent urinary tract infections in hospital caused by his catheterisation. His diminishing reserves made him increasingly unable to respond to antibiotics and he died 11 March 2020 from pulmonary oedema and pneumonia caused by the infections and other underlying health conditions.

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) I heard evidence that Mr Humphries' pressure sore probably started in A&E where he stayed for a long period before being moved to a ward. I was not informed of any skin integrity assessments or measures whilst he was in A&E. (2) When Mr Humphries resisted being turned, no advice was sought from external professionals or the nursing home as to how to manage the situation. The nursing home in particular had effectively employed a range of strategies to deal with the situation and would have been able to provide guidance had the staff been contacted.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 26 October 2021. 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 am under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find ituseful or of interest. In this case, I have sent it to Mr Humphries' daughters. 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.
9	 **Jonathan Landau, HM Assistant Coroner** **1 September 2021**