Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Department of Health & Social Care

1 CORONER

I am Professor Catherine Mason, Her Majesty's Senior Coroner for the area of Leicester City and South Leicestershire.

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 Seventh May 2020 I commenced an investigation into the death of Jane Lesley Bruce aged 54. The investigation concluded at the end of the inquest on Twenty-Eighth October 2021. The conclusion of the inquest was:

Narrative Conclusion - Professional opinion is that Ms Bruce's changed presentation on the 30th April 2020 was indicative that something was wrong, and her care should have been escalated for medical review. Therefore, there was a missed opportunity to treat sooner. Medical opinion is that had antibiotics been commenced, on a balance of probabilities, the outcome would unlikely have been different. However, medical evidence is that the escalation should have been to the hospital where the impending sepsis would have been identified sooner and on a balance of probabilities the outcome would have been different.

The cause of death was established as:

I a Sepsis

I b Fracture Related Infection Right Tibia

I c Fracture Right Tibia, Fibula

II Chronic alcohol dependence

4 CIRCUMSTANCES OF THE DEATH

Jane Bruce presented to the Leicester Royal Infirmary on the 24th November 2019 with a right lower leg injury following a fall at home. A fracture of the right tibia and fibula was diagnosed and

surgically repaired with a circular frame on the 27th November 2019. Ms Bruce was seen as an out-patient in the fracture clinic on the 29th January 2020 when it was identified that the fracture was displaced and treatment with external fixation was not working. Therefore, she underwent further surgery on the 24th February 2020 and discharged home on the 24th March 2020 with wound care to be provided by the community nursing team twice a week. Healing progressed slowly but Ms Bruce appeared to be recovering until on the 29th April 2020 her pain increased rendering her bed-bound and the exudate from the wound significantly increased. Ms Bruce was seen by a District Nurse as planned the following day and informed of the increasing pain, that Ms Bruce was now bed bound and the increasing exudate by Ms Bruce's carer. The dressing was changed, and the dressing frequency was increased to three times a week. Ms Bruce continued to deteriorate and then presented to the Leicester Royal Infirmary for the last time on the 1st May 2020 with features consistent with sepsis. Despite being appropriately treated at the hospital she died the following day.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:
Ms Bruce was care for in the community by several different District Nurses. This meant that it was not the same nurse who was always seeing the wound. No photographs were taken for continuity / reference to and the electronic records could not be accessed by the District Nurses while they were in Ms Bruce's home. This meant that all information that could have been available was not. This meant that Ms Bruce's change in condition was not fully appreciated.

Leicestershire Partnership Trust have learned from this and District Nurse now have work mobile phones so that they can take photographic evidence of wounds as well as IT technology that means they can access the electronic records while they are with the patient. In addition, they also have a 'sepsis' bag containing equipment to record the blood pressure, oxygen saturation levels and temperature.

Although this lesson has been learned and changes made to prevent future deaths locally, the concern is that the practice that was in place at the time of Ms Bruce's death may be practice elsewhere.

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 24 December 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 have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted], Leicestershire Partnership Nhs Trust, University Hospitals of Leicester Nhs Trust, [redacted]

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.

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Professor Catherine E. Mason
H.M. Senior Coroner
Leicester City & South Leicestershire

Honorary Professor
East Midlands Forensic Pathology Unit
(Leicester Cancer Research Unit)

Dated: 29 October 2021