REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) The NHS Lewisham Clinical Commissioning Group** **(2) The London Borough of Lewisham, Adult Social Care Department**
1	**CORONER** I am **HENRIETTA HILL QC**, Assistant Coroner, for the coroner area of Inner South District of Greater 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** **DAPHNE MCCORKLE**, then aged 93 years, died on 20 November 2014. An investigation into her death was opened on 28 November 2014 and an inquest held over 19 April 2016 and 8 September 2016. The medical cause of Mrs McCorkle's death was recorded as follows: I(a) Sepsis I.(b) Infected pressure sore II. Pancreatitis and right sided cerebral infarction I returned a narrative conclusion as follows: *Mrs McCorkle was discharged from hospital on 2 October 2014 with a Grade 2 pressure sore. This deteriorated while she was being treated in the community and on 4 November 2014 she was admitted to hospital (University Hospital, Lewisham). She died there on 20 November 2014 as a consequence of sepsis caused by the pressure sore, which had become infected.*
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows: (1) Mrs McCorkle was discharged from hospital on 2 October 2014 with a Grade 2 pressure sore. (2) On discharge from hospital a care plan required that she be visited by District Nurses while she was in the community. (3) I accepted expert evidence to the effect that there were a range of

issues with the care Mrs McCorkle received from the District Nurses (which had to some degree been accepted by the Trust).

(4) These issues included concerns about (i) the number of visits that were made to see Mrs McCorkle; (ii) the quality of the assessments at those visits; and (iii) the quality of the documentation (which meant one could not be confident that the proper assessments were carried out or plans put in place).

(5) Further, (iv) there had been inadequate reviews of the care plans that were made; and (v) by the time Mrs McCorkle's pressure sore became a grade 3 pressure sore (on 18.10.14) the Tissue Viability Nurse should have been contacted, but this did not occur until very late in the chronology (on 31.10.14).

(6) Finally there was evidence before me that (vi) the District Nurses had not provided the professional carers or members of Mrs McCorkle's family with advice that they should have received to ensure regular turning of her at night.

(7) I accepted the expert evidence that in many cases if they are properly treated, pressure sores can be reversed in terms of their classification and that if proper, or the best, treatment is given, pressure sores can be avoided entirely

(8) However Mrs McCorkle's pressure sore did deteriorate and she became very unwell in late October 2014. On 4 November 2014 Mrs McCorkle was admitted to hospital (University Hospital, Lewisham). She died at University Hospital, Lewisham on 20 November 2014 as a consequence of sepsis caused by the pressure sore, which had become infected.

(9) I concluded that on the balance of probabilities, the issues with Mrs McCorkle's care by the District Nurses, as identified above, more than minimally contributed to her death.

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 that:

(1) On the expert evidence, there will be cases where a patient should be turned every 2/3 hours, even at night, to ensure that the risk of pressure sores being caused or worsened is properly managed.

(2) In some cases where this level of turning is required, family members will not be able to perform that task.

(3) However I was informed during the inquest that Lewisham District Nurses (for whom I understand the NHS Lewisham Clinical Commissioning Group is responsible) will not visit patients at home at night.

	(4) I was also informed that agency carers (whose care I understand is commissioned by the London Borough of Lewisham, Adult Social Care Department) will not visit at night either. (5) This leaves a gap in provision for some patients and is a concern.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 November 2016. 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 Mrs McCorkle and Lewisham and Greenwich NHS Trust. 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	**Signed** .....***Henrietta Hill QC***..... **Assistant Coroner**