REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] Registered Manager, Lynmere Nursing Home, 278 Buxton Road, Great Moor, Stockport, SK2 7AN

CORONER

I am Chris Morris, Area Coroner for Greater Manchester South.

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

INVESTIGATION and INQUEST

On 28th August 2019, Alison Mutch OBE, Senior Coroner for Manchester South, opened an inquest into the death of Norman Baxter, who died at Stepping Hill Hospital Stockport on 8th August 2019 aged 87 years.

The coronial investigation concluded with the inquest which I heard on 18th and 21st February 2020. At inquest, it was determined Mr Baxter died as a consequence of

1) a) Severe sepsis and septic shock

b) Infective exacerbation of Chronic Obstructive Pulmonary Disease and e-coli infection of unconfirmed origin.

II) Type 2 diabetes, probable myeloma, previous hip fracture resulting in girdlestone procedure.

The inquest concluded with a narrative conclusion, to the effect that Mr Baxter died as a consequence of complications of Chronic Obstructive Pulmonary Disease and an e-coli infection. Whilst this is a natural cause of death, it is likely his death was contributed to in part by a previous hip fracture sustained in hospital which ultimately required a girdlestone procedure.

CIRCUMASTANCES OF THE DEATH

Mr Baxter had been slowing down and showing signs of decline when he was admitted to Stepping Hill Hospital, Stockport in December 2018. There, he underwent investigations amidst a concern he was suffering from myeloma. An incidental finding on one such investigation was an undisplaced subcapital hip fracture which required surgery. A hemiarthroplasty was performed, but Mr Baxter ultimately required a girdlestone procedure having fallen again on the ward and dislocating his prosthetic hip.

Once medically fit for discharge, Mr Baxter required nursing care and as such moved into Lynmere Nursing Home in Stockport. There he settled well essentially, but from time-to-time developed chest infections.

On 7th August 2019, a carer noticed Mr Baxter had become unwell. A Registered Nurse working an agency shift took observations throughout the day, but several hours passed before an ambulance was finally called. Mr Baxter died in hospital the following day.

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. –

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.

1. The court heard evidence that, at the time Mr Baxter was cared for at Lynmere, nursing observation charts were not in use. Nursing observation charts, when completed, may assist staff in appreciating an acute episode of illness, or deterioration in a resident's condition. This may particularly be the case were the observation chart to be used in conjunction with a system such as NEWS2, an aggregate scoring system intended to standardise the assessment of, and response to, acute illness.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 16th June 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to Mr Baxter's son and daughter-in-law.

I have also sent it to the Care Quality Commission and Stockport MBC 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.

Dated: 22nd April 2020

Signature: 

Chris Morris HM Area Coroner, Manchester South.