	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ms [redacted] Chief Executive, Royal Cornwall Hospital**
1	**CORONER** I am Andrew Cox, the Acting Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 20 October 2020, I concluded an inquest into the death of Raymond Claude Woodhouse who died in RCHT on 11 February 2019. The medical cause of death was recorded as: 1a) Bronchopneumonia 1b) 1c) II) Parkinson's disease, Infected bursitis (operated), Osteoarthritis of the knee (operated) I recorded a Narrative Conclusion that Mr Woodhouse died from a known complication (infection) of a necessary surgical procedure (total knee replacement.)
4	**CIRCUMSTANCES OF THE DEATH** Mr Woodhouse suffered with severe Parkinson's disease. He also had debilitating pain in an arthritic left knee. The family obtained specialist advice about the risks of a knee replacement procedure and were advised that, while some risk was unavoidable, a key to a successful outcome was to ensure the administration of his prescribed Parkinson's medication post-operatively. On 5/1/19, Mr Woodhouse fell and suffered a cut to his elbow that required stitching. On 16/1/19, Mr [redacted] performed a total knee replacement at St Michael's. The operation itself went well. On 21/1/19, without Mr [redacted] being advised, Mr Woodhouse was transferred to RCHT (Karenza ward) for post-operative delirium and related complaints. Mr Woodhouse developed an infected left elbow. There was a delay in the administration of anti-biotics – possibly due to CRP levels not being checked – and Mr Woodhouse required a wash-out in theatre. Mr Woodhouse's knee became infected and also required a wash-out. He deteriorated and died on 11/2/19.
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 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. i) The family complained they were unable to get staff on Karenza ward to listen to them. It was accepted in evidence that, at the time, there were staffing

	difficulties on the ward that have since been addressed. ii) A lack of cleanliness with Mr Woodhouse being left in soiled bedding and clothes. It was not possible at inquest to come to a view that this was the cause of the infections in the knee and/or elbow. iii) Potential delay in the administration of antibiotics. In evidence, Dr [redacted] accepted that with the benefit of hindsight this was the case. While it was not causative of the death it was possible this had resulted in an avoidable wash-out in theatre; iv) Delays or omissions of prescribed Parkinson's medication. Matron [redacted] had reviewed the nursing records. She accepted in evidence that there were 'multiple' occasions when medication was given late and three occasions when it was not given at all. She conceded nursing standards had fallen below what could reasonably be expected. The inquest was told this is a national problem coming out of the difficulties caused where a patient needs time-specific medication that falls outside traditional ward times for the administration of medication. I was also informed that a business case has been prepared for consideration by the Board for the appointment of a specialist Parkinson's nurse and pharmacist. It was not known whether the case had been accepted and, if so, when it will be taken forward.
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. It is in relation to the business case for a specialist Parkinson's nurse and pharmacist that I write to you. It would seem to me that this would be a sensible step to take that would prevent similar future deaths. There was also an issue about the lack of knowledge of nurses generally in relation to specialist prescriptions for conditions like Parkinson's. I felt that could be addressed by training that a specialist appointee would be well-placed to lead. I wondered also if it would make sense for this cohort of patients (post-operative Parkinson's patients) to go to a default ward where an in-patient stay was required. This would have the benefit of allowing the nurses on that ward to build up specialist knowledge. The family offered an observation that Mr Woodhouse's nursing care improved significantly following his transfer from Karenza ward to a trauma ward. I accept this will always have to be subject to bed availability but it is a matter I felt appropriate to report to you for consideration.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 December 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 Persons (the family of Mr Woodhouse). 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	**[DATE] 21/10/20 [SIGNED BY CORONER]**