University College London Hospitals
NHS Foundation Trust

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30th January 2023

HM Senior Coroner ME Hassell
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Dear Ma'am,

Re: Mr Richard Shannon Prevention of Future Death report

We write to provide you with a detailed response to the Regulation 28 report dated 5th December 2022, regarding the death of Professor Richard Shannon on 19th February 2022. We have worked together, in an integrated way, across the organisations involved in Professor Shannon's care, to provide a thorough response covering all nine areas of concern raised in your report, as relevant across the agencies. Several changes to practice and procedure have already taken place since the safeguarding enquiry outcome meeting on 3rd February 2022. We are each committed to continuing to implement the learning and improvements highlighted. This includes both within our individual organisations, and between our organisations, to improve the co-ordination and communication of care arrangements for our residents and patients which is of paramount importance to us.

1	**This response is made on behalf of** [redacted] Acting Chief Nurse, University College London Hospitals NHS Foundation Trust
2	**Regulation 28 Report** This response follows a report by Coroner ME Hassell on 5th December 2022
3	**Investigation and inquest** On 11 March 2022, I commenced an investigation into the death of Richard Thomas Shannon aged 91 years. The investigation concluded at the end of the inquest on 24 November 2022. I made a narrative determination at inquest as follows. "Professor Shannon died as a consequence of an extremely severe pressure ulcer. This developed at some point between his discharge from hospital on 5 January and his readmission on 13 January 2022, in all likelihood between 10 and 13 January. Whilst a pressure ulcer for a person with his co-morbidities (most particularly immobility and diabetes) is a natural cause of death, there was a failure properly to monitor his skin integrity in his final days.

	If his skin integrity had been properly monitored and he had been appropriately treated, he would not have developed a pressure sore of that severity and would not have died." The medical cause of death was: 1a pneumonia 1b coccyx osteomyelitis 1c infected sacral pressure ulcer 2 type II diabetes mellitus, previous stroke and previous throat cancer
4	**Circumstances of the death** When Professor Shannon was discharged from University College London Hospital on 5 January 2022, his sacral pressure ulcer was almost completely healed. When he was readmitted on 13 January 2022, his condition was irretrievable. His sacral pressure ulcer was now 5-6cms in diameter, covered in black, necrotic tissue, and unstageable. The infection that penetrated to the bone killed him.
5	**Coroner's concerns** The MATTERS OF CONCERN are as follows. 1. The discharge team at University College Hospital (UCH) did not seek a pressure relieving bed and mattress to replace Professor Shannon's own before he was discharged on 5 January. This was because his sacral pressure ulcer was almost fully healed and so they did not consider it necessary. However, he was at risk of further pressure ulcers and so it was a measure that should have been sought. The changing of a bed is more difficult to organise once the patient is home and sleeping in it. If the Central London Community Healthcare district nursing team at Soho Centre for Health and Care (the district nurses) had been invited and had attended the UCH discharge planning meeting, it is much more likely that this measure would have been considered. 2. Upon discharge, UCH sent a referral to the district nurses. This included notification of a grade 2 pressure ulcer and a high risk of pressure ulcers in the future. Professor Shannon had three significant risk factors. He was immobile, he had diabetes, and he had already suffered a pressure ulcer. The UCH nurses expected the district nurses to check the skin integrity every day. The district nurses did not intend to include this in their daily tasks when they attended the home to assist with insulin administration for diabetic control and with catheter care. If the district nurses had been invited and had attended the UCH discharge planning meeting, this misunderstanding could easily have been identified and the true position understood by all. 3. The district nurses expected the carers employed by Kapital Care UK Limited (the Kapital carers) and commissioned by social services at the City of Westminster Council (social services) to check the skin integrity every day. However, there is no record that they issued such an instruction. Even if individual district nurses had sought to issue such an instruction to Kapital carers, the district nurses only attended the home once a day and did not always

meet the carers. When the nurses did meet the carers, they rarely saw the same carer twice. 4 Individual district nurses could not ensure that such an instruction was issued to all carers who attended Professor Shannon. This instruction had to be given at a higher level and passed on to each and every Kapital carer.

4. Upon discharge, a Discharge to Assess form was completed by therapists (I am unclear whether occupational or physiotherapists) at UCH and sent to social services at the City of Westminster. The form raised a number of concerns, but did not specifically instruct that carers should check skin integrity every day. That was an omission.

5. The City of Westminster social worker considering the Discharge to Assess form did not consider any part of the form other than the specific instructions. She did not include in her thinking the record a little further down the same page that Professor Shannon had a grade 2 pressure ulcer and was at high risk of developing pressure ulcers. She told me that she was a social worker and not medically trained to read the Discharge to Assess form. However, she accepted that the form clearly stated that Professor Shannon had a grade 2 pressure ulcer and was at high risk of pressure ulcers. She said that she did not issue a specific instruction to Kapital to check skin integrity every day.

6. When a district nurse arrived at the home the morning after discharge, she found that Professor Shannon's catheter bag was so full it had become detached, and he had demonstrably and significantly soiled himself. He had been in this condition when a Kapital carer had visited earlier that same morning, but the carer had not cleaned him or changed the catheter bag. It took the district nurse three hours properly to take care of her patient's needs. Carers from Kapital had been booked to visit Professor Shannon's home for an hour four times each day by the City of Westminster. One of their specific tasks was to attend to the personal hygiene needs of this elderly and vulnerable man who was unable to attend to them himself. The Kapital carer's explanation for leaving him in this condition was that there was no soap or towel in the property. This excuse struck me as demonstrating an appalling lack of humanity and I was shocked to hear of it. 5 In fact, Professor Shannon was obviously dearly loved, and his friends had done everything they could do to make his home ready for him, including stocking his bathroom with soap and towels readily found by the district nurse. Apparently, the Kapital carer had simply not opened the bathroom cupboard.

7. The City of Westminster undertook a safeguarding investigation after Professor Shannon's death. In that investigation, intended to learn lessons for the benefit of others, the City of Westminster investigator accepted, as the social worker had at the time, the explanation given by Kapital that the towels had been brought to the property after the carer's first visit that morning and therefore had not been available to the carer. The investigator did not interview the Kapital carer. He accepted at inquest that he should have done. There was no evidence to support Kapital's assertion and it was in fact completely inaccurate.

8. The safeguarding investigation was concluded by the social worker from Westminster at the end of June 2022, but I was told that there have been no changes made to systems or training in the intervening five months. The social worker has recently emailed partner agencies suggesting a meeting, but no such meeting has taken place. Apparently, no lessons have been learnt.

	9. What struck me most forcibly throughout the inquest touching the death of Richard Shannon, was that lots of professionals were charged with his care, lots of professionals attended his home, lots of professional met him, yet still very basic elements of his needs were omitted. Despite all the resources expended, he was not cared for as a whole person. In 2022, we must be able to expect better for those in need.
6	**Action taken/timescale** A number of actions were taken including linking with borough partners. UCLH actions relate to concerns 1, 2, 4 and 9 and are detailed below; *1. The discharge team at University College Hospital (UCH) did not seek a pressure relieving bed and mattress to replace Professor Shannon's own before he was discharged on 5 January.* **Actions:** • The Tissue Viability (TV) team at UCLH now document their reviews on the discharge planning section of the patient's electronic health record system (Epic). This was previously completed under another section of the patient notes. This change ensures that the discharge team has a holistic view of the patient's need, including skin concerns / risks and requests for equipment/dressings/skin checks, prior to discharge. This in turn ensures improved communication of risk, from UCLH discharge team to our community and social care partners. • Registered nurses will be trained to add nursing notes (pertinent to discharge and continuity of care), on the discharge summaries on Epic . This has been completed for the senior staff nurses working in the ward (care of older people), where Professor Shannon was a patient. This training has been evaluated and will now be rolled out to specific wards across all hospital sites that link with community and social care partners. This will be review quarterly and reported quarterly through the Harm-free Care Committee and the Nursing and Midwifery Board (chaired by the Chief Nurse). The Trust Patient Safety Committee (PSC) will also be updated on a quarterly basis. • North Central London (NCL) Integrated Care Board (ICB) has developed a NCL tissue viability passport which is designed to be a consistent tool for recording and communicating information about pressure ulcers at the point of discharge and within the community. UCLH discharge and tissue viability teams have contributed to the development of the tool. The tissue viability passport form will be used across NCL hospitals, when signed off by the NCL ICB senior management team. Once finalised, this form will be embedded into the UCLH's Epic system for hospital use. • UCLH has liaised with Central London Community Health (CLCH) to improve links with district nurses. The UCLH discharge team now has the phone number of the district nurses and know that between 2-4pm Monday-Friday, the team will be available to discuss any discharges. • We have set up monthly review meetings with CLCH to ensure the partnership working continues to develop and improve including, enhancing UCLH's understanding of the district nurse role. This will also include joint education and training, to better understand roles and responsibilities and reduce silo working and gaps in care.

- The district nurses have agreed that they will attend meetings with UCLH for any complex patient discharges.
- Westminster City Council has agreed to base a social worker in UCLH to improve communication and joint working across health and social care. ***This started on 23rd January 2023***
- Following discussion with the Islington Transfer of Care Hub Clinical Screener, all referrals should be screened to ensure that the skin section and all nursing sections are completed by the therapist/referrer, prior to them being sent to the community partners. This is the expected process which will be further communicated to staff to ensure clinical information is highlighted and an appropriate care plan identified.

2. Upon discharge, UCLH sent a referral to the district nurses. This included notification of a grade 2 pressure ulcer and a high risk of pressure ulcers in the future. The UCH nurses expected the district nurses to check the skin integrity every day. The district nurses did not intend to include this in their daily tasks when they attended the home to assist with insulin administration for diabetic control and with catheter care.

Actions:

- UCLH has liaised with Central London Community Health (CLCH) to improve links with district nurses. The UCLH discharge team now has the phone number of the district nurses and know that between 2-4pm Monday-Friday the team will be available to discuss any discharges.
- We have set up monthly review meetings with CLCH to ensure the partnership working continues to develop and improve including enhancing UCLH's understanding of the District Nurse role.
- The district nurses have agreed that they will attend meetings with UCLH for any complex discharges.

4. Upon discharge, a Discharge to Assess form was completed by therapists at UCLH and sent to social services at the City of Westminster. The form raised a number of concerns, but did not specifically instruct that carers should check skin integrity every day. That was an omission.

Actions:

- Pressure ulcer training for therapists has commenced in the ward where Professor Shannon was a patient. This includes understanding of the causes and risk factors for pressure ulcers to ensure information/instructions in relation to skin care and risk is communicated clearly on the discharge to assess forms. Regular drop-in teaching sessions continue, as well as planned sessions to ensure all therapists in the trust have had this training by the end of June 2023. This training will be evaluated and reported via the Harm-free Care Committee and the Nursing and Midwifery Board (chaired by the Chief Nurse).

9. What struck me most forcibly throughout the inquest touching the death of Richard Shannon, was that lots of professionals were charged with his care, lots of professionals

	attended his home, lots of professional met him, yet still very basic elements of his needs were omitted. Despite all the resources expended, he was not cared for as a whole person. In 2022, we must be able to expect better for those in need. **Actions:** We have reviewed and improved our local processes and education for staff to prevent further poor outcomes for patients. This is significantly strengthened by working collaboratively with our partners in the community and social care. We are confident this improved approach will enhance the quality and safety of the hospital discharge process and care outside of hospital. We are confident that we have addressed the concerns raised to ensure the care we provide to patients is safe and holistic. To assure ourselves and others, we have agreed to meet monthly as a newly formed partnership to review progress against these actions, share learning and collaborate on improvements.
7	**This response has been prepared by** [redacted] Deputy Chief Nurse
8	**Date of response** 24th January 2023

Yours sincerely,

[redacted]

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Chief Nurse (Acting)

cc: Cathy Mooney, Director for Quality and Safety, UCLH
Katharine Kandelaki, Claims & Inquests Manager, UCLH