Regulation 28: Prevention of Future Deaths report

Richard Thomas SHANNON (died 19.02.22)

	THIS REPORT IS BEING SENT TO: **1.** [redacted] [redacted] **University College London Hospitals NHS Trust** **University College Hospital** **2nd Floor Central** **250 Euston Road** **London NW1 2PG** **2.** [redacted] [redacted] **Central London Community Healthcare NHS Trust** **Ground Floor 15** **Marylebone Road** **London NW1 5JD** **3.** [redacted] **Chief Executive** **City of Westminster Council** **Westminster City Hall** **64 Victoria Street** **London SW1E 6QP** **4.** [redacted] **Registered Care Manager** **Kapital Care (UK) Limited** **1 Crowndale Road** **London NW1 1TU**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS**

	I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
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**

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.

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.

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.

	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 SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 30 January 2022. 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 following. • [redacted] friend of Professor Shannon • [redacted] friend of Professor Shannon • [redacted] UCH geriatrician • [redacted] UCH senior staff nurse • [redacted], Central London district nurse team leader • [redacted], Central London district nurse deputy team leader • [redacted], formerly City of Westminster social worker • [redacted], City of Westminster social worker & investigator • Care Quality Commission for England • NHS England & NHS Improvement • Professor Chris Whitty, Chief Medical Officer for England • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 05.12.22 *ME Hassell*