ANDREW HETHERINGTON
H M Senior Coroner for North Northumberland and
Acting Senior Coroner for South Northumberland

County Hall, Morpeth, Northumberland NE61 2EF

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Maria Mallaband Care Group and Countrywide Care Homes**
1	**CORONER** I am Andrew Hetherington, Senior Coroner for North Northumberland and Acting Senior Coroner for South Northumberland.
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. http://legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 4 February 2022 I commenced an investigation into the death of Julie Elizabeth Nolan Deceased . The investigation concluded at the end of the inquest on 25 April 2023. The conclusion of the inquest was a narrative conclusion: Died as a result of significant progression of wound damage to the left foot leading to the development osteomyelitis whilst a nursing resident in a care home from 24 December 2021 to 24 January 2022 contributed to by underlying natural disease The cause of death was: 1a Acute Osteomyelitis Left Foot, Bronchopneumonia II Diabetes Mellitus, Chronic Kidney Disease, Stroke
4	**CIRCUMSTANCES OF THE DEATH**

	The deceased had underlying natural disease including diabetes mellitus, hypertension, chronic kidney disease and peripheral vascular disease which placed her at risk of the development of pressure damage and ulceration. On 18 March 2021 the deceased underwent an amputation of her left fourth toe and on 7 July 2021 underwent a left femoro-anterior tibial bypass. On 5 November 2021 the deceased suffered a total anterior cerebral infarction leaving her unable to swallow and requiring feeding through a PEG tub. The deceased was admitted to a care home on 24 December 2021. Upon admission a body map was completed with three areas of pressure damage noted to areas of the left foot described as scabbed and blistered. The deceased was identified as very high risk of developing pressure damage. There was limited documentation of wound management and pressure care and it is unclear the extent to which wound management and repositioning was provided in line with the care plans. There was no referral to tissue viability specialists. On 24 January 2022 the deceased was conveyed by ambulance to Northumbria Specialist Emergency Care Hospital, Cramlington unwell with raised inflammatory markers indicating infection and further significant pressure damage to her left foot. It was reported she had also vomited in her PEG tube whilst which may have led to aspiration. The deceased was found to have acute osteomyelitis and received active treatment including intravenous antibiotics. On 26 January 2022 the deceased was transferred from Northumbria Specialist Emergency Care Hospital, Cramlington to Wansbeck General Hospital. Whilst awaiting transfer to the Freeman Hospital for specialist vascular review the deceased deteriorated with a temperature, low oxygen levels and a high heart rate likely as the progression of infection in her chest, foot or both. On 30 January 2022 the deceased suddenly deteriorated with difficulty breathing, low oxygen saturations and died within Wansbeck General Hospital.
5	**CORONER'S CONCERNS** 1. The deceased was a resident in Astor Lodge Care Home. I am concerned there was limited documentation of wound management and pressure care and it is unclear the extent to which wound management and repositioning was provided in line with the care plans. 2. I am concerned that the Manager and Registered Nurse was the designated nurse for the Care Home for two consecutive days.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 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 Julie Nolan Deceased. 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 11 May 2023 Signed: A. C. Hetherington Andrew Hetherington HM Senior Coroner for North Northumberland and Acting Senior Coroner for South Northumberland