REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Acting CEO, Mid and South Essex NHS Foundation Trust [redacted], Level G, Basildon Hospital, Nethermayne, Basildon, SS16 5NL [redacted]
1	**CORONER** I am Sean Horstead, Area Coroner, for the coroner area of Essex
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 3rd September 2021 I commenced an investigation into the death of Ronald Scott Ashdown, aged 55 years. The investigation concluded at the end of the inquest on the 1st June 2023. The conclusion of the inquest was one of natural causes in the context of an expanded narrative conclusion.
4	**CIRCUMSTANCES OF THE DEATH** Ronald Scott Ashdown (RA) died on the 15th August 2021 at Basildon University Hospital, Nethermayne, Basildon, Essex from complications arising from the severe disability sustained following a cardiac arrest and subsequent significant hypoxic brain injury in 2013. The deceased died from natural causes (aspiration pneumonia) on a background of long-term and severely incapacitating disability following a hypoxic brain injury consequent upon a cardiac arrest sustained whilst asleep in bed in 2013. Over the subsequent years the deceased benefitted from the continued and committed advocacy of his daughter to ensure maximal support for her father from the Coach House Nursing Home where he was a resident and also during his frequent periods as an in-patient at Basildon University Hospital. Prior to his death RA had been admitted to Basildon Hospital on 6th July 2021 with shortness of breath, cough and fever having been noted to tachypnoeic and desaturating at the Nursing Home. He was treated with antibiotics for aspiration pneumonia, a frequently occurring complication of his long-term condition. RA was vulnerable to recurrent infections at the site of the PEG; he had two feeding tubes in situ: a PEG & PEJ. After extensive clinical review, on the 21st July the (buried) PEJ was surgically removed under local anaesthetic and feeding resumed via Jejunal extension placed through the old PEG from 28th July. RA was discharged back to the care of the

	Nursing Home when he was deemed clinically stable on 2nd August 2021 but was readmitted to Basildon Hospital on 12th August after dislodging the Jejunostomy tube; he passed way three days later on 15th August.
5	**CORONER'S CONCERNS** Notwithstanding the finding of a natural cause of death, inquest 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. Upon RA's arrival back at the Nursing Home on 2nd August, staff immediately raised a Safeguarding concern in respect of, *inter alia*, his genitals being covered in a white "cheese" like substance with, additionally, faecal matter in his pubic hair; extensive areas of flaking skin including behind his ears was also identified. Colour photographs were taken and provided to the Trust along with the Safeguarding documentation. Objectively, the photographs clearly documented the flaking skin and white "cheese" like material covering RA's penis. 2. Evidence confirmed that the Mid and South Essex NHS Foundation Trust, responsible for Basildon Hospital, carried out a significantly flawed RCA investigation which effectively rejected any suggestions of shortcoming in care, management and treatment. The Ward Matron (responsible for the ward concerned) was the co-author responsible for the RCA Report. [redacted] gave evidence to the inquest that she had not been provided with the photographs provided by the Nursing Home and RA's daughter until just two weeks prior to the inquest hearing. (It was noted and accepted that even when [redacted] had seen the photographs neither [redacted] nor the Trust had seen fit to draw this to HMC's attention or to provide either an addendum statement or a revised RCA). 3. The Trust's responsible Adult Safeguarding Lead provided a statement in which [redacted] confirmed that, notwithstanding the photos having been expressly noted in the original Safeguarding referral *and* raised in subsequent correspondence and meetings with the Thurrock Local Authority Safeguarding Team, [redacted] had *not* made the photos available for the purposes of the RCA. [redacted] was unable to provide any explanation at all for this failure. This lack of professionalism was and remains a grave cause for concern resulting as it did in a seriously flawed Trust investigation, which itself fed into the Thurrock Adult Safeguarding investigation and, further still, a wider section 42 systemic investigation involving RA's case and two others to which a range of stakeholders contributed. It was accepted by the Trust witnesses that but for the coronial investigation, the denials of any Trust failings would have remained unchallenged perpetuating a false record of the basic nursing care provided (or not provided) to the highly vulnerable and dependent RA. 4. The evidence heard at the inquest undermined the following erroneous findings of the RCA: • In response to the concern that RA had extensive flakes of fungal growth behind his ears the RCA concluded that *"no flakes noted in hospital, documentation supports regular personal care was provided throughout admission."* • In respect to the concern that RA's foreskin/genitals were covered in flakes and what appeared to be "cheese / paste" the RCA asserted that there were *"no flakes noted in hospital, documentation support regular personal care was provided throughout admission."*

	• In response to the concern that RA's pubic hair contained dried faecal matter the RCA asserted that *"documentation (was) found to support (RA) had a full wash on day of discharge back to nursing home."* 5. Having belatedly considered the photographs, the Ward Matron retracted her investigation findings and conceded that for RA's genitals to have appeared as they did in the photographs (taken on the day of his arrival back at the Nursing Home) he would have had to have received "*no basic nursing care in the form of the washing of his genital area for several days"*. [redacted], and the Trust, were obliged to accept that the nursing records purporting to claim that RA "*had a full wash on the day of discharge"* was demonstrably untrue and that, in fact, he had not been washed fully for many days. The extensive areas of flaking skin behind RA's ears were also, contrary to the RCA finding, now accepted. 6. *My principal focussed concerns are therefore:* (a) The extent of the Trust's inexplicable failure to provide critical primary evidence for the purposes of the RCA led directly to an erroneously exculpatory RCA Report; without an accurate and reliable RCA the lessons upon which important changes to Trust systems and practice depend cannot be identified and acted upon in a timely fashion; (b) The evidence confirmed that, despite his clear vulnerability and complete physical dependence on Trust staff providing basic nursing care, including simple personal hygiene, RA did not receive such basic care for an extended period – probably over several days. This does not indicate, as appears to have been suggested at one point by the Trust, a failure in *record keeping* but, rather, a serious failure in the provision of the most basic of nursing care. Running as it did over several days, the evidence confirmed that this failure to provide basic care likely extended beyond one or two members of staff and, further, was simply not picked up by the more senior nurses on the Ward. (c) Although the failure to provide such basic nursing care, in the specific context of RA's identified cause of death (and notwithstanding his vulnerability to infection), had no causal relevance to his death, I am nonetheless entirely satisfied that in myriad other cases the identified failure of this kind gives rise to the obvious risk of infection and consequently the risk of future death. (d) Finally, the evidence confirmed that the misleading failures in the Trust's RCA fed into and undermined the subsequent Thurrock Local Authority Safeguarding Adult Review Investigation and a wider systemic section 42 Safeguarding investigation, both of which will now require review with the concomitant delay involved.
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday 12th September 2023. 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: [redacted] daughter of the deceased; [redacted] and Thurrock Local Authority Safeguarding and [redacted], Business Manager of Thurrock Safeguarding Adults Board; CQC responsible for MSE and Basildon Hospital. 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	 **HM Area Coroner for Essex Sean Horstead** **18.07.2023**