M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

Date: 24 July 2023

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Royal United Hospital**
1	**CORONER** I am Maria Eileen Voisin, Senior Coroner for the Area of Avon
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://www.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 7 July 2022 I commenced an investigation into the death of Alan Christopher NIPPARD. The investigation concluded at the end of the inquest. The conclusion of the inquest was a narrative including a finding of neglect. Mr Nippard's death was caused by a pressure sore. The pressure sore was preventable with the provision of basic nursing care, this was not provided. There was a gross failure to provide basic nursing care. Once he had the pressure sore his death could have been prevented with the provision of basic nursing care, such as, skin care, regular re-positioning and personal care, this was not achieved at all. He was not managed in line with recognised nursing practice and as a consequence his death was contributed to by neglect. The medical cause of death was recorded as: 1a Sepsis 1b Necrotising fasciitis/Fournier s gangrene 1c Pressure sore sacrum II Septic arthritis, Type 2 diabetes mellitus, chronic kidney disease, left ventricular systolic dysfunction
4	**CIRCUMSTANCES OF THE DEATH**

According to Mr Nippard's GP, Mr Nippard had a medical history which included poorly controlled type 2 diabetes, peripheral vascular disease, ischemic heart disease and chronic kidney disease stage 4. He had also undergone amputations of his toes due to non-healing diabetic ulcers.

His daughter, said in evidence that he was admitted to hospital on 30th May 2022 following a fall at home. He said that he'd fallen forward and onto his knee. He was lifted from the floor and onto his bed by his family where he remained until an ambulance was called, when the decision was taken to admit him to the Royal United Hosptial (the RUH) in Bath.

He was admitted via the Emergency department, then to the medical assessment unit (MAU), and then onto the Orthopaedic ward – Pierce Ward on 1st June 2022 in the early hours.

According to the Consultant Orthopaedic Surgeon, Mr Nippard was initially admitted, with the diagnosis of right knee septic arthritis and an acute kidney injury on top of his chronic kidney disease. Mr Nippard was on antibiotics and on 2nd June 2022 underwent a washout of his knee. On 8th June he had a second washout. By 17th June he was deteriorating, on 20th June his CRP was increasing. He said in his evidence that the pressure sore was first documented by the orthopaedic team on 21st June, the surgeon described this now as - the bigger source of infection**.**

An MRI was requested but did not take place for 4 days; it was undertaken on 25th June and reported as showing no obvious sacral osteomyelitis it did show that it had locally spread in the soft tissue.

By 28th June Mr Nippard was getting worse, his inflammatory markers were going up and now his testicles were swollen, and there was a suspicion was that this was Fournier's Gangrene and there was a referral made to the Urology team.

The orthopaedic surgeon said that as far as the treatment for Mr Nippard's knee went, he felt they were winning that it was improving that if he hadn't developed the pressure sore his expectation was that he would have been discharged. He agreed with the medical cause of death proposed.

A Consultant Urologist examined Mr Nippard on 28th June, he said that he had evidence of a significant infection, that the only treatment was surgery, and all agreed that surgery was not likely to help, and it would cause Mr Nippard immense suffering in his last days. He explained that the other medical conditions Mr Nippard suffered with caused him to be compromised, if he'd had a stronger heart and kidneys then they would have operated

Sadly, after discussions with Urologists, Surgeons, Anesthetists and the Critical care team it was decided that Mr Nippard was not fit for surgery, and he was placed on priorities of care and died on 6th July 2022.

It was the view of the doctors who attended the inquest and gave evidence that the pressure sore significantly contributed to Mr Nippard's death.

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 heard from the Trust's Lead Tissue Viability Nurse, [redacted] had reviewed the notes and provided [redacted] opinion on what did happen, and what should have happened, in relation to the nursing care he was provided with.
There were many concerns that she raised, she said in summary the pressure sore was preventable, that it's basic nursing care and this wasn't achieved. That once it had developed, if he'd had good skin care and the SSKIN bundle had been followed the damage would have been minimized. When asked how bad the care was [redacted] said - it was shocking.

It was accepted that Mr Nippard did not have a sacral pressure sore when he was admitted to the RUH and that it was deemed hospital acquired.
That the first time that the sacral pressure sore was mentioned in the notes was on 2nd June 2022 when a Tissue Viability Nurse (TVN) referral was sent, stating - for suspected deep tissue injuries to buttocks with blistering, stating the area appeared overnight.

I was told that there were a number of areas of concern with regard to the risk assessment, management and care and treatment that Mr Nippard received including:

- That the screening tool completed on 31st May scored Mr Nippard as, not at risk of a pressure sore – this was wrong; he was at risk due to his immobility and diabetes which increased the risk of a pressure sore developing, in addition to his age and his medical history. He should have been scored high risk. Because of this - nothing happened and it should have. Mr Nippard should have been on an air mattress and he should have been re-positioned regularly.
- On the MAU he did not have his risk assessment done within 6 hrs as it should have been.
- It is recorded that he was on an air mattress on Pierce ward on 1st June but the time of this is unknown. This meant he probably went up to 2 days after his admission without an air mattress.
- Mr Nippard's risk assessment was not carried out until 2 days post admission, (1st June) it did record his risk as high, this is a significant delay.
- Once recorded as high risk Mr Nippard should have been reassessed every week – this was not achieved.
- The SSKIN bundle, a nationally recognised tool with care plan was rarely completed and when it was it was poorly completed.
- Skin assessments should have been carried out daily, when they were carried out were ad hoc and inaccurate, sometimes skin was recorded as

	normal when it clearly wasn't. • On one occasion a body map was circled indicating the areas of concerns – sacrum and left heel but lacked information and categorisation • Of significant concern is the fact that Mr Nippard spent long periods of time on his back with little or no evidence of offloading of the sacrum or heels at all. He should have been repositioned every 2-3 hours during the day and between 2-4 hours at night. There was no structured re-positioning at all. • It was estimated that every day he was in hospital he was on his back for 22 ½ hours and there was no sustained time off his sacrum and there should have been. • When he was sat in his chair there is no evidence that he had an air cushion to sit on and when sat, he should have been stood hourly. • It was raised that there was a query of his own compliance but there is only 2 occasions on 6th and 20th June when he declined to be moved • There was no evidence of the use of 2 sliding sheets to assist with moving him. • On 11th June it was a podiatrist who raised the new pressure sore on the right heel and completed an incident report – this should have been managed and picked up by the nurses in their daily checks. In addition he should have had repose boots to prevent this and there is no evidence they were used at all. • Mr Nippard had a catheter and incontinence – he should have been checked regularly, offered the toilet, the commode, bed pans should have been a last resort. She could not see this was achieved at all. The fact Mr Nippard was left to soil the bed was not acceptable care and that the limited personal care described by the family was not acceptable. • Fluid balance charts were poorly completed. • He wasn't weighed which would have assisted with managing his oedema. • Appropriate nursing care was not achieved and pressure care was a fundamental part of nursing care. I have been advised that The Trust have taken significant steps since Mr Nippard's admission, however, I have not been reassured by those involved with Pierce Ward that this will not happen again. Specifically, I have been advised by The Lead Tissue Viability Nurse that she has ongoing concerns and indeed The Interim Deputy Divisional Director of Nursing for Surgery and The Divisional Director of Surgery have confirmed that there have been two pressure sore incidents on Pierce Ward this month (July 2023). I have been told that the reason for this could be the need for training of staff on Pierce Ward on : risk assessment, prevention care and treatment of pressure sores by the tissue viability team.

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 21st 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 - family of the 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	24 July 2023 Signature  Maria Voisin Senior Coroner for Avon