MR GRAEME IRVINE
SENIOR CORONER
EAST LONDON
East London Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], **North East London Foundation Trust (NELFT), CEME Centre, March Way, Rainham, Essex, RM13 8GQ Email:** [redacted] 2. [redacted], **Chief Executive, London Borough of Redbridge Council,** [redacted], **Operational Director of Assurance,** [redacted] 3. **Rt Hon Steve Barclay MP, Secretary of State for Health & Social Care, 39 Victoria St, Westminster, London SW1H 0EU** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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 15th December 2022, this Court commenced an investigation into the death of Donna Levy aged 51 years. The investigation concluded at the end of the inquest on 22nd August 2023. The conclusion of the inquest was a narrative conclusion;

	"Donna Rose Lydia Levy died in hospital on 14th December 2022 due to complications of a pressure sore she developed in the community. The pressure sore developed due to self-neglect despite support from community health organisations." Ms Levy's medical cause of death was determined as; *1a Sepsis secondary to pressure sore* *II Frailty secondary to self-neglect*
4	**CIRCUMSTANCES OF THE DEATH** Donna Levy was housebound. She was admitted to hospital by ambulance as she had become critically unwell. On admission she was observed to present with signs of severe self-neglect. Ms Levy was found to be suffering from a significant number of skin lesions on her chest, armpits, anterior lower legs and the entirety of her posterior lower limbs reaching as far as her sacrum. Ms Levy had moisture lesions on her buttocks and thighs along with an ungradable pressure sore which had become infected. Ms Levy had severely oedematous lower limbs, the skin on her legs and feet had extensive cellulitis which had caused chronic ulceration, discoloration and a tree-bark texture. Her toenails were long, infected and discoloured. The deceased had extensive uterine fibroids that had progressed to the stage that they impeded her mobility and continence. Ms Levy had clinical signs of sepsis and a stage two acute kidney injury. The patient was admitted to hospital by ambulance and underwent surgical debridement of dead ulcerated skin and tissue, following surgery she succumbed to infection despite maximal medical support and died on 14th December 2022.
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 could 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. Since 2020 Ms Levy had been provided with domiciliary care commissioned by the local authority. At the time of her death twice daily visits were undertaken. Ms Levy was utilising state funded domiciliary care visits to deliver fast food to her home, no personal care was being provided. Carers had escalated to the local authority Ms Levy's reluctance to accept personal care and raised safeguarding reports regarding Ms Levy's living conditions. 2. In the two months prior to her final admission into hospital Ms Levy was being regularly assessed by district nurses, the community matron and her GP. Despite the obvious nature of her deteriorating health, no meaningful steps were taken to escalate the care she received to mitigate the risks of her self-neglect. 3. The inquest heard that as Ms Levy was believed to have capacity throughout this period, and consequently it was determined that there were on practical steps that could have been taken to improve the provision of care to her. 4. No formal Mental Capacity Act assessment was ever undertaken or considered.

	5. No formal referral was made to mental health services regarding Ms Levy's reluctance to take advantage of offered care. 6. The Trust responsible for community care did not undertake a Serious Investigation. The decision was justified on the basis that Ms Levy's pressure sore was insufficiently significant to justify further inquiry. The decision was, in the view of the court flawed as evidence heard indicated that the pressure sore was in fact far more serious than appreciated at the time of community treatment. Further, restricting the scope of a serious incident report to the extent of a single pressure sore, neglected to take in the wider physical health problems suffered by Ms Levy that were obvious at that time.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 **26th October 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 the family of Mrs Levy, the Care Quality Commission. I have also sent it to the local Director of Public Health who may find it useful or of interest. 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]** 31st August 2023 **[SIGNED BY CORONER]**