**IN THE SURREY CORONER'S COURT**
**IN THE MATTER OF:**

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**The Inquest Touching the Death of Linda Oldland**
**A Regulation 28 Report – Action to Prevent Future Deaths**

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| 1 | **THIS REPORT IS BEING SENT TO:**<br><br>[redacted]<br>Chief Executive<br>Leonard Cheshire<br>66 South Lambeth Road<br>London<br>SW8 1RL |
| 2 | **CORONER**<br>Miss Anna Crawford, H.M. Assistant Coroner for Surrey |
| 3 | **CORONER'S LEGAL POWERS**<br>I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009. |
| 4 | **INQUEST**<br><br>An inquest into Ms Oldland's death was opened on 21 January 2022. The inquest was resumed and evidence was heard on 30 September 2022, 3 October 2022 and 30 June 2023. The inquest concluded on 3 July 2023.<br><br>The medical cause of Ms Oldland's death was:<br><br>Ia Sepsis.<br><br>Ib Bilateral pyelonephritis.<br><br>Ic Bilateral renal calculi treated with bilateral ureteric stents<br><br>The inquest concluded with a narrative conclusion as follows: |

Ms Oldland was a 61 year old woman who lived at Hydon Hill Nursing Home, run by Leonard Cheshire.

Ms Oldland had severe progressive multiple sclerosis and as a result she was bedbound and had minimal communication abilities. She also suffered from chronic kidney disease and kidney stones with bilateral ureteric stents, and a related history of recurrent urine infections.

On 3 January 2022 Ms Oldland died at Hydon Hill Nursing Home. Her death was due to a urinary tract infection which infected both her kidneys and resulted in sepsis. Her kidney stones and ureteric stents contributed to her developing the urinary tract infection.

On 31 December 2021 Ms Oldland's GP from The Mill Medical Practice visited her at Hydon Hill Nursing Home. Given her history the GP thought she may be in the early stages of urinary sepsis. She therefore prescribed stand-by antibiotics to be commenced if Ms Oldland deteriorated, including by way of a reduction in consciousness levels. The GP also asked for Mrs Oldland to be admitted to hospital if she began to show signs of sepsis. This was in accordance with the wishes Ms Oldland had set out in her Proactive Anticipatory Care Plan (PACE). The GP also asked for a urine sample to be taken and delivered to the surgery for testing.

During the consultation with the GP on 31 December 2021, the staff at Hydon Hill Nursing Home did not inform the GP that Ms Oldland had had a positive urine dip stick test the previous day.

After the urine sample had been delivered to the GP surgery later that afternoon, staff at the GP surgery carried out a positive dipstick test before sending the sample off for further testing at the laboratory. Ms Oldland's GP was not made aware of the second positive dip stick test.

In the event that that Ms Oldland's GP had been informed of either of the positive dipstick test results, Ms Oldland would have been immediately commenced on oral antibiotics and her life would have been prolonged, albeit it is not known what her ultimate prognosis would have been.

On the evening of 31 December 2021, Ms Oldland's consciousness levels deteriorated and from that point onwards until lunch time on 2 January 2022 there was a delay on the part of Hydon Hill Nursing Home in commencing the standby antibiotics.

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| | In the event that the antibiotics had been commenced on 31 December 2021, Ms Oldland's life would have been prolonged, albeit it is not known what her ultimate prognosis would have been.<br><br>On 2 January 2022 Ms Oldland's blood pressure deteriorated and staff at the nursing home called 999 and an ambulance attended from South East Coast Ambulance Service (SECAMBS). Ms Oldland was not transferred to hospital and discharged back to the care of her GP.<br><br>Hydon Hill staff did not inform SECAMBS that Ms Oldland had had a positive urine dipstick test on 30 December 2021 and that the plan arising from the GP consultation on 31 December 2021 was for her to be admitted to hospital should she show signs of sepsis and that this was in accordance with Ms Oldland's intentions as recorded in her PACE document.<br><br>In the event that this information had been passed on to SECAMBS Ms Oldland would have been transferred to hospital and her life would have been prolonged, albeit it is not known what her ultimate prognosis would have been.<br><br>Ms Oldland's death was contributed to by neglect on the part of Hydon Hill Nursing Home. |

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| 5 | **CIRCUMSTANCES OF THE DEATH**<br><br>The circumstances of Ms Oldland's death are as recorded in the narrative conclusion set out above.<br><br>In addition, the court found that on 3 January 2022, the day that Ms Oldland died, a nurse checked on her at approximately 13:00 and found her to be pale and unresponsive and called an ambulance. Whilst waiting for the ambulance the nurse reported to the telephone operator that Ms Oldland was breathing very slowly and had a weak pulse. As a result, life support measures were not implemented prior to the ambulance arrival. However, on the arrival of the ambulance paramedics found Ms Oldland to be cyanosed and in a state of cardiac arrest. They did not commence life support measures as they were informed by nursing home staff that Ms Oldland had a valid Do Not Attempt to Resuscitate (DNAR) form in place. Ms Oldland was declared deceased at 13:24.<br><br>The court found that Ms Oldland had in fact entered into cardiac arrest at some unknown point prior to the arrival of the ambulance crew. The court also found that Ms Oldland did not have a valid DNAR in place and her express wish, which had been recorded in her PACE form, was to be resuscitated in the event of a cardiac arrest.<br><br>It is of considerable concern that the trained nurses at the care home were unable to recognise that Ms Oldland was in a state of cardiac arrest. It is also a matter of considerable concern that staff did not know what Ms Oldland's wishes were in the event of a cardiac arrest and therefore did not commence life support measures on 3 January 2022.<br><br>However, the court was not persuaded that life support measures would have materially improved Ms Oldland's clinical course on 3 January 2022. Accordingly, the court was not persuaded that the absence of life support measures on 3 January 2022 contributed to Ms Oldland's death. |

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| 6 | **CORONER'S CONCERNS**<br><br>The **MATTER OF CONCERN** is:<br><br>Hydon Hill Nursing Home:<br><br>- Did not pass on pertinent information to the GP about the positive dip stick test on 30 December 2021;<br>- Delayed the start of the stand-by oral antibiotics from the evening 31 December 2021 until Midday on 2 January 2022;<br>- Did not pass on pertinent information to the ambulance service on 2 January 2022 about Mrs Oldland's wishes and the GP plan should she deteriorate with suspected sepsis;<br>- Did not recognise that Ms Oldland was in a state of cardiac arrest on 3 January 2022;<br>- Incorrectly informed the ambulance service that Mrs Oldland had a valid DNAR in place on 3 January 2022.<br><br>The Coroner considers that consideration ought to be given to updating policies and procedures in respect of the sharing and documentation of information relating to residents and/or in relation to training of clinical staff to address the above matters. |
| 7 | **ACTION SHOULD BE TAKEN**<br>In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action. |

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| 8 | **YOUR RESPONSE**<br>You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed. |
| 9 | **COPIES**<br>I have sent a copy of this report to the following:<br><br>1. Chief Coroner<br>2. [redacted] (Brother)<br>3. South-East Coast Ambulance Service (SECAMBS)<br>4. The Mill Medical Practice |
| 10 | **Signed:**<br><br>**ANNA CRAWFORD**<br><br>**Anna Crawford**<br>**H.M Assistant Coroner for Surrey**<br>**Dated this 14th day of August 2023** |