From the Acting Chief Executive and Registrar

Nursing & Midwifery Council

Sally Robinson
Assistant Coroner
The Coroners Courts & Office
The Guildhall
Alfred Gelder Street
Kingston upon Hull
HU1 2AA

By email only to: [redacted]

Ref no: [redacted]

23 September 2024

Dear Ms Robinson

Linda Heath – NMC response to Regulation 28 Prevention of Future Deaths Report

Thank you for sending your Regulation 28 Prevention of Future Deaths Report (PFD) in connection with the death of Linda Heath for us to review in accordance with paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. I write on behalf of the Nursing and Midwifery Council (NMC) to confirm the action we are taking in response to the concerns raised.

Firstly, I am very sorry to hear about the circumstances of Linda's death and I would like to offer my sincere condolences to her family for their loss. We take the concerns you have raised with us very seriously.

We have used the information in the PFD to reflect on the action we can take to address the concerns you have identified and to make sure they do not occur again where we have the power to do so. We set out below the action we have taken to ensure that the professionals on our register are fit to practise safely and professionally and that the public is protected in line with our role.

Additionally, I would like to apologise for the delay in acknowledging and responding to your report. We are taking steps to identify why the report did not reach the correct team in time for us to respond in accordance with the statutory deadline and will make appropriate improvements to prevent this from happening in future.

Your concerns

I note that your investigation concluded that Linda died at Hull Royal Infirmary from sepsis caused by an infected sacral sore, also known as a pressure sore. Linda had been discharged in February 2022 with a grade 2/healing sore. A combination of management issues by healthcare professionals, including her not being referred for district nursing care, led to a worsening of her condition. Along with Linda's pre-existing co-morbidities this led to an admission to Hull Royal Infirmary on 5 March 2022. Despite surgical treatment the situation worsened. Tissue viability nursing was not reinstituted post-operatively. Difficulties in care with nutrition and hospital acquired infections unfortunately led to Linda's death on 31 March 2022.

You have raised the following concerns in the PFD report:

1. The Immediate Discharge Summary did not include relevant or sufficient information about treatment in the community needs or a nursing summary.

2. Despite the presence of a difficult sacral sore which would have benefitted from district nursing care, no referral was made post discharge by the GP surgery.

3. No trigger appears to exist whereby General Practitioners conduct follow up enquiries or visits to patients who have recently been discharged from hospital and who are complaining of a condition which may worsen and failing to attend routine appointments due to a worsening of their condition.

4. An over reliance upon private hygiene care packages with insufficient inquiry into the parameters of care provided by the private domiciliary carers.

Our role

The NMC is the independent regulator of more than 808,000 nurses and midwives in the UK and nursing associates in England. We're here to protect the public by upholding high professional nursing and midwifery standards, which the public has a right to expect. We maintain the integrity of the register of those eligible to practise and we investigate concerns about individual professionals.

Our Code of Conduct contains the professional standards that registered nurses, midwives and nursing associates must uphold. We will investigate alleged breaches of the Code when we become aware of them under our fitness to practise process.

We have two clear aims for fitness to practise:

a. a professional culture that values equality, diversity and inclusion, and prioritises openness and learning in the interests of public safety, and

b. nurses, midwives and nursing associates who are fit to practise safely and professionally.

In appropriate circumstances we enforce the standards set out in the Code through fitness to practise proceedings. Fitness to practise proceedings can result in a range of outcomes, ranging from the provision of advice to the registrant by the NMC to removal from the register.

Our response to the concerns raised

The concerns that you have raised indicate that a nurse or nursing associate's skills, knowledge, education or behaviour may have fallen below the standards needed to deliver safe and effective care.

Your report has been shared with our fitness to practise department, who will screen the case in accordance with our fitness to practise process. We screen cases to make sure that we're the right organisation to address the concerns and it's serious enough that regulatory action needs to be taken. It's important to note that more often than not, employers can deal with most cases without the need for regulatory action.

In line with our screening process, we will now take steps to:

- confirm whether the concerns you have raised relate to a professional or professionals on our register;
- establish if there is evidence of a serious concern that could require us to take regulatory action to protect the public;
- confirm if there is clear evidence to show that a nurse, midwife or nursing associate is currently fit to practise.

If concerns are identified that relate to someone on our register, our screening team will carry out an initial risk assessment in relation to each concern. If they identify particular risks, such as a risk of harm to the public, the case may be referred to an interim order hearing. Interim order cases may include cases of serious lack of competence or poor clinical practice. An interim order has the effect of restricting the nurse or nursing associate's practice with immediate effect.

To help with our screening enquiries, we contacted your office on 23 August 2024, 5 September 2024 and 16 September 2024 to obtain further information. We have sought disclosure of the Serious Incident report to help us with our enquiries and are waiting for a response.

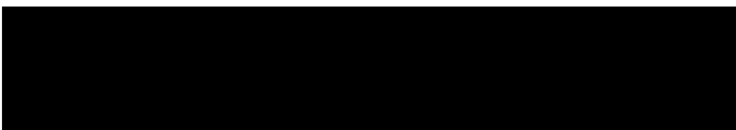
Finally, we recognise the impact that FtP proceedings can have on families, which is why we have a Public Support Service (PSS) to help support people through the process and understand how the investigation process works. Through it, our public support officers can answer individual questions or provide one-to-one meetings and help explain the different decisions that could be made. If we do proceed with an investigation our PSS team will reach out to Linda's family to offer support. More information about our PSS can be found here NMC public support service - The Nursing and Midwifery Council.

Conclusion

We are taking steps to investigate the concerns raised to identify whether we need to take regulatory action in relation to a professional or professionals on our register. We are also making enquiries to ensure PFD reports are shared across the organisation more swiftly in the future.

Once again, I offer my heartfelt condolences to Linda's family. If you have any further questions concerning this case or the steps we are taking, please do not hesitate to contact us.

Yours sincerely



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