Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Chief Executive of East Sussex Healthcare NHS Trust**
1	**CORONER** I am Rachel REDMAN, Assistant Coroner for the coroner area of East Sussex
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 04 November 2022 I commenced an investigation into the death of Carol Ann DIVALL aged 74. The investigation concluded at the end of the inquest on 26 April 2024. The conclusion of the inquest was that: C A Divall suffered from Alzheimer's disease for the previous 7 years before she sustained a hip fracture at home on 15th September 2022. She had been living at home and was looked after by her husband. She was admitted to the Conquest Hospital where it was repaired on 16.9.22. She was not discharged until 24.10.22 to the care of the Community Nursing Team who immediately assessed Mrs Divall as requiring end of life care. Mrs Divall died on 29.10.22 at home.
4	**CIRCUMSTANCES OF THE DEATH** C A Divall suffered from Alzheimer's disease for the previous 7 years before she sustained a hip fracture at home on 15th September 2022. She had been living at home and was looked after by her husband. She was admitted to the Conquest Hospital where it was repaired on 16.9.22. She was not discharged until 24.10.22 to the care of the Community Nursing Team who immediately assessed Mrs Divall as requiring end of life care. Mrs Divall died on 29.10.22 at home.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) A. That Mrs Divall developed severe oral thrush making it very difficult for her to eat and drink and take her oral medication. She was referred to the dietitians on 2.10.22 and triaged by an Assistant the following day. She was not prescribed Fortisip until 14.10.22 by which time she was becoming malnourished. The oral thrush continued until discharge. Nystatin appeared to be prescribed once on 12.10.22 and was not prescribed on discharge nor mentioned in the discharge summary. I heard evidence on PFD matters that software which requires a clinician to check oral care is being implemented. I remain of the opinion that this forms part of basic nursing care which was overlooked in Mrs Divall's case.

	B. Mrs Divall was referred to the Physiotherapy Department 2 weeks after admission but was rarely assisted with mobilisation and left to sit out in her chair for long periods. Action should have been taken to encourage Mrs Divall to mobilise more often in an attempt to rehabilitate her after her surgery. C. Mrs Divall developed a grade 4 sacral pressure sore. She was not referred to the Tissue Viability Nurse until 1.10.22 who confirmed in her evidence that it would have taken 12-14 days to develop and would therefore have been available to be seen by the nursing staff caring for her. Contributing to the deterioration of her pressure sore was the deflating of her hybrid mattress on at least 2 occasions. Mr Divall noticed who visited for long periods every day noticed that his wife was never repositioned as she should have been on a 2 hourly basis at any time during his daily visits. I consider that Mrs Divall's immobility and malnourishment contributed to the development of her pressure sore the care of and severity were not mentioned in the discharge summary. D. The Discharge Summary was misleading to the District Nurses who were unaware of the severity of Mrs Divall's pressure sore until they saw it (down to the bone) and did not make clear that Mrs Divall had been discharged for end of life care. E. The RCA was insufficient and did not address all of the issues surrounding Mrs Divall's care nor did it properly address those issues it did consider.
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 July 09, 2024. 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] 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 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 by the Chief Coroner.
9	**Dated: 14/05/2024** Rachel Redman **Rachel REDMAN**

	Assistant Coroner for **East Sussex**