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:** **Norfolk Community Health & Care NHS Trust (NCHC)** **Woodlands House** **Norwich Community Hospital** **Bowthorpe Road** **Norwich** **NR2 3TU**
1	**CORONER** I am Jacqueline LAKE, Senior Coroner for the coroner area of Norfolk
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 20 November 2023 I commenced an investigation into the death of Kenneth George Willard KING aged 76. The investigation concluded at the end of the inquest on 26 November 2024. **The medical cause of death was:** 1a) Septic Shock 1b) Bilateral Leg Cellulitis 1c) 2) Type Two Diabetes Mellitus, Hypertension **The conclusion of the inquest was:** Mr King died from septic shock due to bilateral leg cellulitis. His wounds were not always dressed in accordance with the recommended time scales.
4	**CIRCUMSTANCES OF THE DEATH** Mr King had a significant medical history. He was referred to the Community Nursing Team in June 2023 due to a wound on his right ankle. Mr King was rereferred in July 2023 when he had three wound sites. He was seen and continued to receive assessment and dressings to his wounds in the community. At various times there were delays in Mr King being seen in accordance with recommendations sometimes by five or six days. Mr King was at times prescribed antibiotics. On 10 October 2023 blood tests were taken and Mr King's inflammatory markers were significantly elevated. He attended hospital but then self-discharged. He returned to hospital the next day and was admitted. Following intravenous antibiotics he was discharged to Ambulatory care on 14 October 2023 and returned to hospital on a daily basis for intravenous antibiotics until 21 October 2023, (not attending on 20 October 2023) when he was discharged to community care with oral antibiotics for five days. Mr King was not referred to the community nursing team. An urgent visit by community nursing was requested on 27 October 2023 when Mr King had signs of infection. On 28 October 2023 Mr King was triaged and seen that day and his dressings were

	changed. Mr King was seen on 31 October and on 5 November 2023 when his dressings were changed. Swabs were taken on 8 November 2023 when a huge amount of strike through was noted on the left leg and a moderate amount of exude green in colour present on the right leg. Evidence was heard there was a mild malodor. Mr King's dressings were changed on the morning of 10 November 2023. Evidence was heard there was no malodor and no sign of infection on this occasion neither of which is referred to in the written records. A referral was made for increased visits. Later that day Mr King was admitted to Norfolk and Norwich University Hospital with cellulitis of both legs, being generally unwell and confused. Mr King's condition continued to deteriorate and he died on 12 November 2023 from septic shock due to bilateral leg cellulitis.
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) NCHC have taken action and put in place many steps to prevent future deaths. However, I do have two ongoing concerns as follows: 1. Evidence was heard that there is no formal structure in place as to when or with regard to the frequency of carrying out physiological observations on patients in the community. Observations are required to be taken if the attending clinician has any concerns about the patient's wellbeing or a deterioration in their condition, or at the request of a senior clinician or GP. No specific questions are asked of the patient, such as if they are feeling unwell, have pain or localised heat, the attending practitioner relies on general conversation carried out at their attendance to help form a view as to whether observations are required to be taken. It was accepted in evidence that the decision to perform observations relies on the clinical judgment of the relevant clinician, which is a subjective decision which may be exercised incorrectly and at variance with other clinicians. Different clinicians carry out visits in the community and so have no overall view of a patient's presentation and any deterioration. Written records are available but evidence was heard that in this case, on the last visit, the record of the previous attendance was looked at and no history prior to that. Evidence was heard that Health Care Practitioners may have limited clinical training and rely on instructions and advice from trained nurses. In this case, evidence was heard that Mr King presented as feeling well but had high inflammatory markers, which may mask when observations are required to be carried out. Some patients may not be forthcoming about any symptoms unless specifically asked. 2. Mr King died a year ago and although there is a training programme which is being devised and rolled out it is not expected to be in place for a further eighteen months. The policy to prevent bank staff applying for roles when they have not undergone the required training is not yet in place.
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 January 22, 2025. 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 the Deceased ▪ Fosters Solicitors, Legal Representative for the Family ▪ Legal Services, Norfolk and Norwich University Hospital I have also sent it to ▪ Department of Health and Social Care ▪ Care Quality Commission (CQC) ▪ HSSIB (Health Services Safety Investigations Body) ▪ Healthwatch Norfolk ▪ NHS ENGLAND & NHS IMPROVEMENT 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 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: 27/11/2024** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH