Report to Prevent Future Deaths

Sheila Josephine WEXLER (Date of death: 17 February 2024)

	Regulation 28 Report to Prevent Future Deaths
	THIS REPORT IS BEING SENT TO: 1. Chief Executive Nottingham Rehab Limited (trading as NRS Healthcare) Sherwood House Cartwright Way Forest Business Park Bardon Hill Coalville Leicestershire LE67 1UB 2. National Medical Director NHS England Wellington House 133-155 Waterloo Road London SE1 8UG
1	**CORONER** I am Ian Potter, assistant coroner for Inner North 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.
3	**INVESTIGATION and INQUEST** On 29 February 2024, I commenced an investigation into the death of Sheila Josephine WEXLER, aged 87 years at the time of her death. The investigation concluded at the end of an inquest on 14 January 2025. The conclusion of the inquest was a short narrative conclusion in the following terms: 'natural causes, contributed to by increased immobility as a result of delayed and defective turning equipment being supplied for the treatment of a pressure ulcer.' The medical cause of death was: 1a bilateral pulmonary embolism II dementia, ischaemic cerebral stroke, pneumonia, frailty, grade 4 sacral pressure ulcer

4	**CIRCUMSTANCES OF DEATH** Mrs Sheila Wexler lived with dementia and other significant comorbidities for a number of years. In the months prior to her death, she was thought to be entering the final phase of her life and a package of maximal home treatment was in place as a ceiling of care. In January 2024, Mrs Wexler developed an unstageable sacral pressure ulcer. The district nursing team ordered equipment from an external supplier (NRS Healthcare) which, among other things, would turn Mrs Wexler regularly to assist in the treatment of the pressure ulcer. There were delays in some of the equipment arriving and the turning equipment was not properly functioning. An engineer attended Mrs Wexler's home, on behalf of NRS Healthcare, to repair the equipment, but used a pump that was not compatible with the turning system. As a result of these issues with the equipment, Mrs Wexler's immobility was significantly increased for a period of days, which added to her underlying risks of developing a pulmonary embolism. Mrs Wexler died at home on 17 February 2024. The immediate cause of her death was bilateral pulmonary embolism. A number of her comorbidities contributed to this. The increased immobility as a result of delayed and defective equipment being supplied also more than minimally contributed to her death.
5	**<u>CORONER'S CONCERNS</u>** During the course of my investigation and the inquest, the evidence revealed a matter 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. For context, NRS Healthcare is a nationwide supplier of medical equipment for use in people's own homes and it has contracts with numerous NHS bodies and others, to supply and maintain such equipment. In this specific case, NRS Healthcare was required to provide and install medical equipment (at the request of one of the district nursing teams that are part of Central and North West London NHS Foundation Trust). This equipment included, a lateral turning system (known as a TOTO), an air mattress, and side rails for a profiling bed. The principal need for the equipment was for assistance in treating a sacral pressure wound. It was confirmed in evidence, the order for the equipment from NRS Healthcare was placed correctly on 10 January 2024, on a next day delivery basis. The **MATTERS OF CONCERN** is, as follows: <u>NRS Healthcare related matters</u>:

	I heard evidence of a delay in delivering some of the required equipment, which in turn meant a delay in the patient being able to make use of the equipment. The delay meant that the patient's family, carers, and the district nursing team underwent a period of time in which they were unable to provide the patient with the optimal care required in relation to the pressure ulcer. When the TOTO turning system arrived it was defective. An urgent repair/replace request was made to NRS Healthcare, which resulted in an engineer attending the patient's home to replace the pump on 23 January 2024. However, despite advising that they had replaced pump with a like-for-like pump, it transpired that the replacement pump was a 'Tri-Pos Bariatric Alternating Air Cushion' pump. This replacement pump had none of the settings that would allow the proper and effective use of the TOTO system. In this instance, the TOTO system was required to turn the patient from one side to the other every 60 minutes. I was told in evidence that equipment issues would have added to the patients 'pain and distress' and the fitting of the incorrect pump meant that the patient was not being turned every 60 minutes, as required. Again, this creates the risk that those caring for the patient were precluded from providing an optimal level of care. While the presence of a pressure ulcer, in itself, did not add to the underlying risk of the patient developing a pulmonary embolism, the delayed and defective equipment provided significantly increased the patient's immobility in the weeks prior to her death. There was evidence that immobility is a major risk factor in the development of pulmonary emboli. I heard evidence that issues with delays and defective equipment from NRS Healthcare persist to date. <u>NRS Healthcare and NHS England related matters</u>: I heard evidence that since being awarded the contract to provide such equipment, there had been numerous and ongoing delays and 'problems' in the service provided by NRS Healthcare. The evidence was such that the repeated issues and concerns had actually been placed on the Trust/Integrated Care Board's (ICBs) risk register. While I heard that there had been some improvement, I was told that the service provided was still 'not great'. While this particular case is the first in which I have formed the opinion that delayed and defective equipment has created a risk of future deaths, I have heard similar evidence of delayed and defective equipment issues relating to NRS Healthcare in other inquests concerning different NHS Trusts and ICBs. On that basis, I am also of the opinion, given NRS Healthcare's operations are not confined to organisations within this coroner area, that the risks posed are likely to be more widespread and that action should be taken more widely.
6	**ACTION SHOULD BE TAKEN**

	In my opinion, action should be taken to prevent future deaths and I believe that you 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 12 March 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 Mrs Sheila Wexler • Central and North West London NHS Trust I have also sent a copy of my report to the following, for information: • NHS North East London Integrated Care Board • North Central London Integrated Care Board I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted summary form. She may send a copy of this report to any person who she 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	**Ian Potter** HM Assistant Coroner, Inner North London 15 January 2025