REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

<table>
<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1 Multi-Care Community Services Suffolk</td></tr>
<tr><td>1</td><td>CORONER

I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On 25 September 2023 I commenced an investigation into the death of Peter PETTIT aged 86.

The investigation concluded at the end of the inquest on 05 February 2026.

The conclusion of the inquest was:

Narrative Conclusion - Peter PETTIT, an 86-year-old man, was a much loved and desperately missed member of his Family. His Family recalls him as a loving, caring, proud husband, father and grandfather who was committed to his family and local community.

Mr. PETTIT had a previous medical history of Ankylosing Spondylitis, Crohn's Disease, Hypertension, Peripheral Vascular Disease, he was pre-diabetic, had Prostate Cancer, Chronic Kidney Disease Stage 3 and Diverticular Disease. Mr. PETTIT had an indwelling catheter inserted.

At the time of his death, Mr. PETTIT was under the care of urologists at West Suffolk Hospital for his prostate cancer. Mr PETTIT did not have a formal diagnosis of dementia but there was clear evidence of some cognitive impairment/decline due to his fluctuating memory, poor short-term recall and often not being orientated to time. This had adversely impacted on Mr. PETTIT in terms of his catheter and medication management and for which he required assistance provided by carers who at the time of his death would attend his residence 4 times a day. His carers would, amongst other things, assist with monitoring his medication compliance and assist in personal care including catheter management.

On the 31st August 2023 Mr. PETTIT presented to West Suffolk Hospital Accident and Emergency Department complaining of pain due to the fact that he had not passed urine for a period of time. He was diagnosed as suffering from acute urinary retention following the dislodgement of his urinary catheter. His catheter had been found to have been displaced and it was reinserted. The catheter was likely displaced some 5 days prior to his attendance at hospital. This was not documented in the records of the care company providing Mr. PETTIT's care and there is no evidence of catheter management by the care company in the five days leading up to the 31st August hospital attendance.</td></tr>
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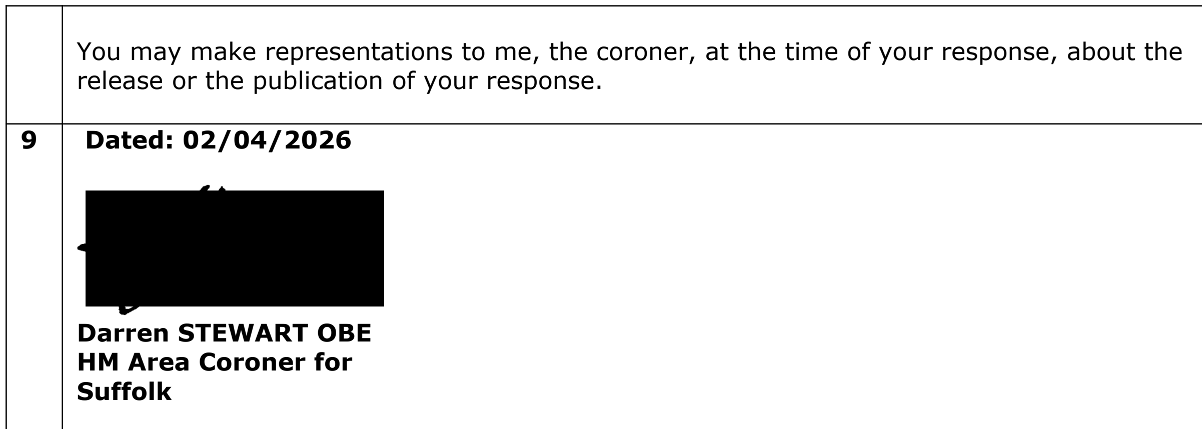
	It is likely that this period of urine retention following catheter displacement in late August 2023 was when Mr. PETTIT contracted a urinary tract infection. It is unclear whether earlier attention to Mr. PETTIT's catheter displacement and urine retention would have had an impact on the severity of the infection he subsequently suffered. **On the 2nd September 2023 Mr. PETTIT suffered a fall on stairs at his residence. Ambulance attended and assessed Mr. PETTIT as having sustained a cut to his right hand and grazes to the back of his head which were dressed. He was offered the opportunity to attend hospital which he declined. Ambulance staff left a note for his carers. When Mr. PETTIT's carers next attended in the middle of the day, he had deteriorated, complaining of back pain and was found on the floor having slumped down from the chair he had been sitting on. He was taken to hospital where he was assessed as having suffered a displaced rib fracture and was showing signs of suffering from a urinary tract infection. This was subsequently confirmed with Klebsiella bacteria having been grown on samples taken from Mr. PETTIT.** **Mr. PETTIT's condition progressively worsened over the subsequent days despite treatment with Mr. PETTIT requiring increasing levels of oxygen support. He contracted pneumonia which contributed to his decline. By the 10th September 2023 his prognosis was poor and he was referred to the palliative care team. Peter PETTIT sadly died on the evening of the 11th September 2023.** **A postmortem examination determined his medical cause of death as sepsis due to bronchopneumonia and acute pyelonephritis. Peter PETTIT died from a naturally occurring condition.** The medical cause of death was confirmed as: **1a. Sepsis** **1b. Bronchopneumonia, Acute Pyelonephritis** **2. Ischaemic and Valvular Heart Disease**
4	**CIRCUMSTANCES OF THE DEATH** **Narrative conclusion see part 4.**
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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: **MultiCare Community Services Suffolk** Record keeping relating to the Suffolk County Council commissioned care provided to Mr. PETTIT was found to be inadequate, with significant gaps in records relating to frequency of attendances and details of actions taken during any atendance. The effect of these gaps in the records meant that there was no evidence carers had attended, nor undertaken commissioned care support actions for Mr. PETTIT, including assistance with medication and catheter management for periods of time extending up to several days. In addition to poor record keeping, evidence heard during the Inquest raised concerns as to the adequacy of the support provided to Mr. PETTIT in the

	management of his medication. Stockpiles of medication were found at the residence clearly reflecting a lack of compliance by Mr. PETTIT in his medication regimen; support to Mr. PETTIT in medication management was a service Multi-Care Community Services Suffolk were commissioned to provide. No formal concern in relation to non-compliance with medication was raised by Multi-Care Community Services Suffolk with either the commissioning authority (Suffolk County Council), or Mr. PETTIT's General Practice. Mr. PETTIT's catheter management, both in terms of day-time changing and support to fitting of a night time catheter, were part of the services Multi-Care Community Services Suffolk were commissioned to provide. The Inquest heard evidence that catheter management for Mr. PETTIT was poor, with periods of days, possibly longer, where there was an absence of catheter support provided to Mr. PETTIT. It is possible that Mr. Pettit did not receive support in relation to his night-time catheter changes for several months. Training material and records provided to the Court suggested that no formal, assurred training arrangements were in place to deliver the commissioned care to Mr. PETTIT. Evidence of subsequent actions following Mr. PETTIT's death provided no confidence to the Court that inadequacies in training, assurrance and management identified at the time of Mr. PETTIT's death have subsequently been addressed.
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 May 28, 2026. 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: **Family of Peter PETTIT** **Suffolk County Council** I have also sent it to: **Care Quality Commission** 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 other 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.
9	**Dated: 02/04/2026**  **Darren STEWART OBE** **HM Area Coroner for Suffolk**