Your ref :

Our ref APM/BJF/MILLER

HER MAJESTY'S CORONER
Manchester West

Mr John Saxby
Chief Executive
Pennine Care Trust
225 Old Street
Ashton-under –Lyne
Lancashire
OL6 7SR

7th August 2013

Dear Mr Saxby

Jean Miller (deceased)

On 3rd July 2013 I completed the Inquest into the death of Mrs Jean Miller, who died on 24th January 2013 at The Royal Bolton Hospital. The cause of Mrs Miller's death was
1a. multi organ failure;
1b. sepsis;
1c. wound infection following elective incisional hernia repair; and
2. Atherosclerosis

Where a Coroner is satisfied that the evidence at an Inquest gives rise to a concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future, and is of the opinion that action should be taken to prevent the occurrence or continuation of such circumstances, the Coroner may report the circumstances to a person whom the Coroner believes may have power to take such action. I announced at the conclusion of the Inquest that I was proposing to make such a report under Rule 43 of the Coroner's Rules 1984 as amended. This is my report.

The circumstances revealed in the evidence before me included the following:

1. Mrs Miller was born on 19th August 1938
2. On the 14th November 2012 she was admitted to the Royal Bolton Hospital for an incisional hernia repair operation.
3. She remained a patient at the Royal Bolton Hospital for post operative care. Her surgical wound was monitored for potential infection by the staff at the Royal Bolton Hospital.She became hypoxic and as a result her oxygen levels were monitored in addition to the wound.

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4. On 8th December 2012 she was examined by [redacted] who was satisfied that she was medically fit for discharge home under the care of the district nursing team.
5. The District Nursing Team began daily visits to Mrs Miller at her home address from 10th December 2012.Their role was to dress and inspect the wound daily to ensure Mrs Miller did not deteriorate and her wound healed satisfactorily.
6. However they did not baseline her wound when they commenced their care of Mrs Miller and the tissue viability team were not involved by the district nursing team in Mrs Miller's care.
7. Concerns about a deterioration in Mrs Miller's wound resulted in a swab being taken on 18th December 2012.
8. During their care of Mrs Miller the district nursing team carried out a number of checks on Mrs Miller to try to identify if her condition was deteriorating. However I was told that they did not take her temperature whilst caring for her.
9. The inquest was told that district nurses within the trust did not take temperatures as part of their routine care and were not expected to.The inquest was further told that the district nurses were not issued with thermometers as part of their medical kit when caring for patients.
10. One of the district nurses indicated that if she was worried a patient had a temperature then she would check their forehead to see if they felt hot.
11. Mrs Miller was readmitted to the Royal Bolton Hospital on 24th December 2012 with what was described as a purulent discharge from the wound site. She received treatment at the Royal Bolton Hospital following her admission including further surgical intervention and was on the intensive care ward. She died on 24th January 2013 at the Royal Bolton Hospital.

The evidence I heard at the Inquest established that:

1. The wound was not of concern at the time of discharge from the Royal Bolton Hospital and had there been concerns Mrs Miller would not have been discharged.
2. The district nursing team were not able to fully monitor any possible deterioration of the wound in the absence of a baseline assessment
3. The specialist services of the Tissue Viability team were not accessed by the District Nursing Team
4. The basic nursing check of temperature taking using a thermometer was not carried out by the district nursing team and there was no expectation of such an action being carried out by their management team
5. District Nurses with the Pennine Trust are not issued with thermometers to assist them in the care of patients
6. The quality of the notes kept by the District Nursing Team was poor
7. There was limited communication with the GP notwithstanding the proximity of the District Nurses to the GP
8. Mrs Miller's wound had significantly deteriorated by the time the District Nursing Team identified she could no longer be cared for at home and required readmission to hospital

My main concerns arising from the Inquest are:-

1. The quality of care offered by the district nursing team arising from poor

practices being in place in particular a lack of baseline assessments and poor understanding of the need to involve tissue viability specialists in such cases as Mrs Miller's
2. The lack of basic equipment issued to the District Nursing Team in particular thermometers
3. Poor record keeping by the District Nursing Team
4. Poor communication by the District Nursing Team with the GP

Accordingly, I request the Trust to carry out a review of:

1. How the quality of patient notes are assessed and procedures to ensure that there is substantial improvement in the quality of record keeping.
2. The equipment issued to the District Nursing Teams to ensure that all District Nurses are in a position to carry out basic nursing checks such as temperature checks
3. The systems in place for carrying out baseline assessments of patients under the care of the District Nursing Team
4. The understanding of the District Nursing Team of the role of the Tissue Viability Team and when their expertise should be utilised
5. Methods of and recording of communication with GPs

By virtue of Rule 43A(i) as a recipient of this report you must provide me with a written response to it containing details of any action taken or which it is proposed be taken. This must be provided within fifty six days beginning with the day upon which this report is sent. If you wish to request longer than this period to respond you should write to me requesting an extension of time and giving reasons.

In accordance with Rule 43 a copy of this report is being sent to the Secretary of State for Health and all other properly interested persons identified at the Inquest. A list of recipients can be found at the end of this letter. Your response will be shared with those listed.

I look forward to hearing from you.

Yours sincerely

Alison P Mutch
H M Assistant Deputy Coroner
Greater Manchester County (West)

Copies to :-

Secretary of State for Health
[redacted]