REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Royal College of General Practitioners** **2. Royal College of Nursing**
1	**CORONER** I am Joanne Kearsley, HM Area Coroner for the area Manchester South.
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 the 24th October 2012 I commenced an investigation into the death of Dorothy Townley, 94 years of age. The investigation concluded at the end of the Inquest on the 20th August 2013. The conclusion of the Inquest was that the deceased died as a result of an accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On the 28th September 2012 at her home address the deceased had spilt a cup of tea, sustaining burns which developed and became infected. There were missed opportunities to consider earlier hospital intervention. On the 11th October 2012 she was admitted to hospital but despite active treatment her condition deteriorated and she died on the 20th October 2012. Having spilt her tea on the 28th September she was washed and changed by her carer who was present. The next day the area on her chest looked a little red, however by the 30th two blisters had developed and the carer called the District Nurses. District Nurses attended that day and applied dressings to the blistered area which by this stage had burst. She was then seen the following day when a prescription for further dressings was written and she was listed for visits every 2 days. On the 3rd October the dressings had not been delivered and by this stage her chest and left breast area were exuding from blistered areas and looked sore. She was changed to daily visits. On the 4th October more skin loss was noted and a GP visit was requested as it was felt that the site was infected. Her GP visited the following day on the 5th October. This was not a joint visit. In evidence the GP indicated he had received a request to visit Mrs Townley. He did not examine her chest as this would have meant taking the dressing off her and it was his belief that there were no replacement dressings available in the property. He looked and could see the superficial wounds on the outer edges which "looked to be healing ok". He did not prescribe antibiotics as he felt they were not required, he did prescribe Flamazine cream. He indicated in evidence that to a large extent, in relation to wound care, GPs are led by the nurses. The District Nurses continue to visit. On the 6th October they are concerned about her condition. Her wound and condition continue to deteriorate. On the 10th October the District Nurses request a further GP visit. The GP re-attends; again this is not a joint visit. Her dressing is not removed and antibiotics are not prescribed. He notes the

	deterioration in her condition, that she had visibly deteriorated, was very dehydrated and not keeping much down. However he stated that he did not think this was related to her wound. In evidence the GP indicated that he planned to take a blood test from Mrs Townley, he could not do this at the time of his visit on the 10th as he did not have the equipment to do so although he felt that a blood test was required urgently. There was then some confusion in the evidence as to what happened but it appears that on return to the GP practice on the 10th a request was made to the District Nurses to take a blood test from Mrs Townley. This was not marked as urgent. On the 11th October the GP re-attended Mrs Townley's address on the chance he would see her and take the blood test (it was not known by him whether in fact the District Nurses would have already done this.) As this was an unscheduled visit Mrs Townley was on her own in the property and was too poorly to be able to open the door. He left the property and as he was aware that the District Nurses would be calling later that day did not do anything further. When the District Nurses attended on the 11th they called the Out of Hours Doctor who immediately admitted Mrs Townley to hospital. She was transferred immediately to the Specialist Burns Unit at Wythenshawe Hospital, who immediately raised a safeguarding alert with regards to her condition. It was recorded that she had 5-6% second degree burns covering most of her upper chest. These were infected; she was very dehydrated and had atrial fibrillation. The Consultant who gave evidence at the Inquest confirmed that in a 94 year old lady with frail skin this was a significant burn which had developed; he would have expected her to be referred to them much sooner. Despite all active treatment Mrs Townley died on the 20th October. During the Inquest I heard evidence from the Clinical Lead for District Nursing who indicated that at the time of this incident there was nothing in place within the District Nursing Service to help them deal specifically with burns. The Wound Assessment Chart used was not suitable for recording burns. There was no consideration of referral or input being requested from the OUTREACH service at the Specialist Burns Unit (a service in place at the time where specialist trained nurses can offer advice to community nurses/doctors on the management of burns).
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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. There was a lack of direct communication between the District Nurses and the GP as to exactly what the deceased's condition was and what was required on visits. There was no consideration given to carrying out joint visits, no communication as to how Mrs Townley's wound could be examined if there were no dressings available. 2. There was a lack of knowledge within the District Nursing Team around the treatment of burns. 3. The wound assessment chart did not assist as it was not as detailed as it should be for burns in order to help chart their progress or deterioration. 4. There was a lack of training for District Nurses on the treatment of burns. 5. There was a lack of understanding between the GP and District Nurses as to how to request urgent blood tests. It was assumed by the GP that his request for a blood test would be treated as urgent and done that day (on 10th); the

	District Nurses indicated it would only be carried out as 'urgent' if requested.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 24/10/13. 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] (son of the deceased), Bredbury Medical Centre and Stockport District Nursing Team. 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 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	**Date:** 29.8.13
	Signed by: [signature]