

A R W Forrest LLM, FRCP, FRCPath GMC Number: 1333523 Her Majesty's Senior Coroner for South Lincolnshire

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. Acting Chief Nurse, United Lincolnshire Hospitals NHS
	Trust, Lincoln County Hospital, Lincoln, LN2 5QY
1	CORONER
	I am ARW Forrest, Senior Coroner for the Coroner's area of South Lincolnshire.
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 16 th October 2013 I commenced an investigation into the death of Iris May
	GRIMWOOD, age 80. The investigation concluded at the end of the inquest on 22 nd
	August 2014. The conclusion of the inquest was NATURAL CAUSES.
4	CIRCUMSTANCES OF THE DEATH
	Iris was well for her age, apart from dizziness for some 14 years which had been treated
	with prochlorperazine. When this drug was stopped her condition deteriorated. She
	developed a tremor which became more prominent after July 2013. From then on her
	condition deteriorated and she went down hill. Drug induced Parkinsonism contributed to
	her symptoms in the early stages of her illness. Lewy body dementia was thought to be
	a cause when she developed visual hallucinations. Concerns were expressed about the
	quality of nursing care during her decline, but no evidence presented suggested that this
	contributed to her death. She died in Pilgrim Hospital on 8th October 2013 as a result of
	her progressive neurological disease.



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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 Evidence from medical staff at Pilgrim Hospital and members of Iris's family included expressions of concern that there were difficulties in providing the level of nursing care that Iris needed. Evidence was also given that mistakes were made in the use of semi-automatic thermometers for measuring body temperature and an episode was described where a nurse attempted to apply an antifungal ointment to Iris's genital region, this having been prescribed for the treatment of oral thrush, before being stopped by a family member. The medical staff attributed these problems to less than optimal numbers of nursing staff, compounded by difficulties in recruitment and retention of nursing staff as well as problems with funding training.

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 **20**th **October 2014**. 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

Quality Care Commission, Citygate, Gallowgate, Newcastle upon Tyne, NE1
 4PA



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	2. 3.
	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	26 th August 2014 ARW Forrest H M Senior Coroner for South Lincolnshire

