Derek Winter
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Ken W Bremner** **Chief Executive** **City Hospitals Sunderland NHS Foundation Trust** **Sunderland Royal Hospital** **Kayll Road** **Sunderland SR4 7TP**
1	**CORONER** I am Derek Winter, Senior Coroner for the City of Sunderland
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 26/03/2014 an investigation into the death of Leonard Henry Hudson, aged 74 was commenced. The investigation concluded at the end of the inquest on 23th September 2014. The conclusion of the inquest was "Accident contributed to by complications arising from diabetes".
4	**CIRCUMSTANCES OF THE DEATH** Mr Hudson fell at his home address on the 12th May 2013 and was admitted to Sunderland Royal Hospital on 13th May 2013 for surgery to repair a fracture of the right neck of femur which appeared to meet it's objectives. Given Mr Hudson's other medical conditions particularly his diabetes he was susceptible to pressure sores the management of which was challenging. On the 16th October 2013 Mr Hudson underwent a below the knee amputation of his right leg. As a consequence of his immobility he developed bronchopneumonia from which he died on the 19th March 2014 at his home address [redacted] Pelton Fell Chester le Street.
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.

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The **MATTERS OF CONCERN** are, as follows. –

During the course of Mr Hudson's in-patient admission from the 13th of May 2013 to the 13th of August 2013, staff did not follow the requirements of the Trust' Prevention and Management of Pressure Ulcers Policy in that incident reports were not submitted.

Due to the co-morbidities of Mr Hudson, he ought to have been identified as having a higher risk factor.

Mr Hudson ought to have been referred to the foot protection team in a more timely manner.

The nursing documentation was not as comprehensive as it ought to have been.

The classification of Mr Hudson's heel injuries was "variable".

From the evidence given by [redacted], the Tissue Viability Specialist Practitioner, that these matters have been or will be addressed and I was encouraged to learn about that, and the Awareness and Training Programme together with the work of the Foot Protection Team.

During the course of the evidence some other matters of concern were raised, particularly those relating to the mobilisation of Mr Hudson. I would like to draw them to your attention, as follows: -

1) there were episodes of inadequate record keeping; for example, although the family had met with medical staff to discuss concerns, there appeared to be no available record or the action taken thereafter; also Mr Hudson was to have the benefit of an Exogen machine for 20 minutes each day to stimulate the healing of the bone, but there appeared to be no records about this;

2) there was confusion about Mr Hudson being moved from the bed to his chair by hoist;

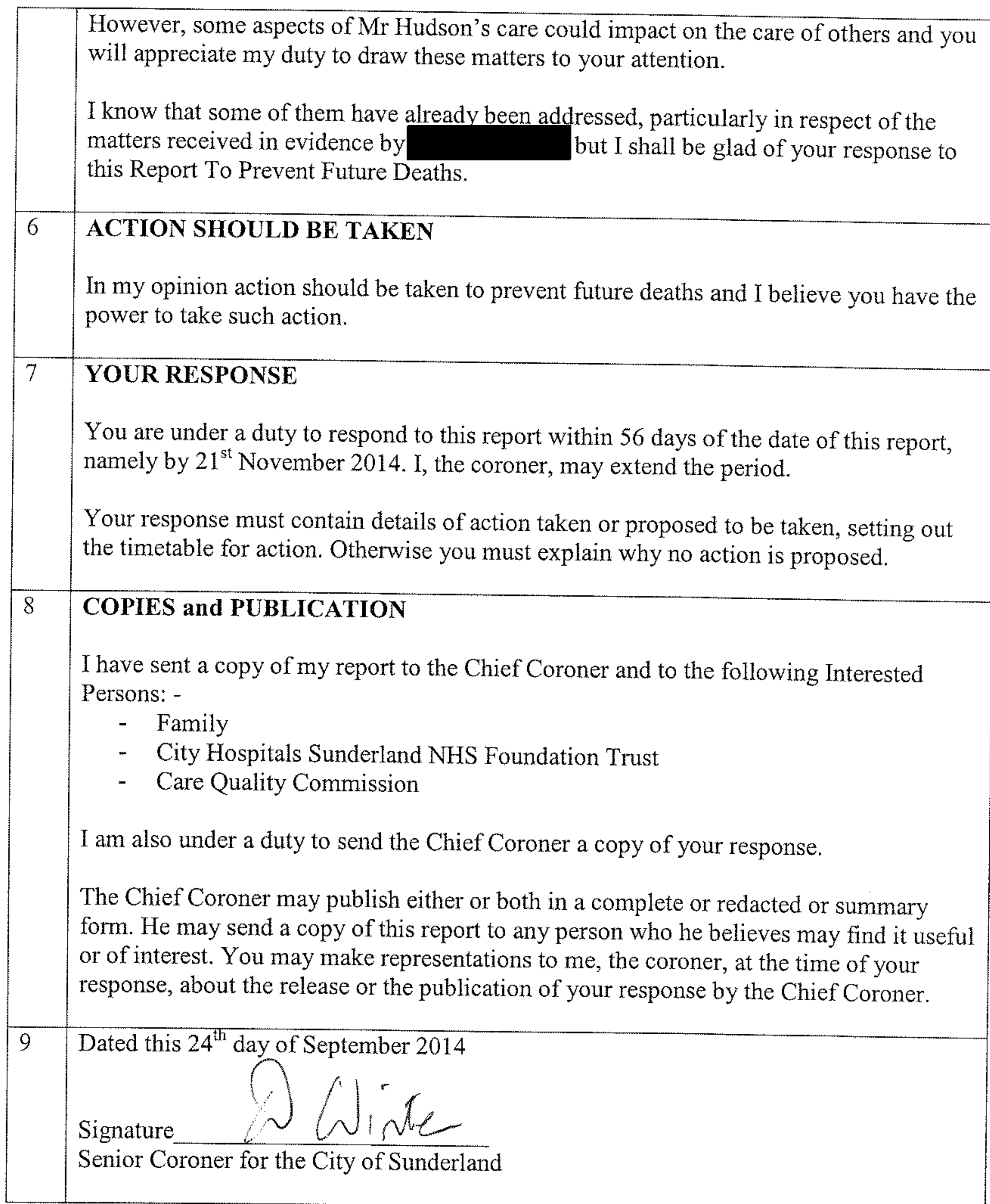
3) there was some degree of confusion about any fluid restrictions for Mr Hudson: the family were under the impression that there would be fluid restriction, but in evidence this appeared to be related to six occasions following Mr Hudson's dialysis;

4) although physiotherapists attended the ward on two occasions per day, Mr Hudson was absent from the ward for three days having dialysis and there was no contingency provision for physiotherapy;

5) there appeared to be some conflict with regard to the arrangements made for Mr Hudson to go to the toilet and whether his hygiene needs were met;

6) it was accepted that Mr Hudson had Type 2 Diabetes but there was an impression that this was Type 1.

All of these matters dented the trust and confidence that the family had in the provision of healthcare and although they submitted to me that Mr Hudson had died of Natural Causes contributed to by neglect, I did not make that finding.



	However, some aspects of Mr Hudson's care could impact on the care of others and you will appreciate my duty to draw these matters to your attention. I know that some of them have already been addressed, particularly in respect of the matters received in evidence by but I shall be glad of your response to this Report To Prevent Future Deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 21st November 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 Persons: - - Family - City Hospitals Sunderland NHS Foundation Trust - Care Quality Commission 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	Dated this 24th day of September 2014 Signature____________________ Senior Coroner for the City of Sunderland