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. **North Somerset Clinical Commissioning Group** 2. [redacted] **sister of the deceased** 3. **North Somerset Community Partnership** 4. **Weston Area Health NHS Trust** 5. **Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Assistant Coroner, for the coroner Area of Avon
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 9th April 2015 I commenced an investigation into the death of Ms. Marilyn Anson age 60 years. The investigation concluded at the end of the inquest on 3rd February 2016. The conclusion was that the medical cause of death was I(a) Myocardial infarction; I(b) Coronary artery thrombosis; II Type 2 diabetes mellitus, hypertension, obesity, cirrhosis and the conclusion as to the death was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered with type 2 diabetes mellitus and required regular dialysis for end-stage renal failure caused by her diabetes. In 2001 the deceased had undergone a below knee amputation of the right leg. During 2013 she attended regularly the Podiatry Clinic but did not keep appointments during 2014 and on 14th November 2014 she telephoned the clinic and discharged herself from the service. The GP was advised of this self-discharge by letter of 11th February 2015. On 13th February 2015 a referral was made by the GP to the North Somerset Community Partnership (NSCP) via their single point of access (SPA) for the community nurses to attend the deceased to examine a skin tear on her leg. For reasons unknown this referral was not acted upon. There is reference in the GP records to a referral being made on 30th January 2015 although it is not known if this referral was actually made at that time. On 25th February 2015 a further referral was made from the GP practice requesting the community nurses to attend the deceased with regard to the skin lesion on her leg which was now reported to be leaking fluid. The community nurse from NSCP attended the deceased at home the following day, the 26th February 2015, accompanied by a colleague. On examination the deceased had already dressed the leg wound herself and did not wish to have the dressing removed at that time. However, at the same time she also complained about pain in her left foot which was covered loosely in an absorbent pad. On examination the community nurse discovered the deceased to have a grade 4 pressure ulcer. The area covered by the ulcer was 8cm x 6cm affecting the heel which was black and necrotic but dry. The community nurse dressed the wound and arranged for the deceased to have appropriate pressure relieving aids including a pressure relieving mattress. In addition an urgent referral was made that same day to the 'hot foot' clinic based at Weston General Hospital. Arrangements were made for the deceased to be seen twice weekly by the community nurse until the appointment at the 'hot foot' clinic. When the deceased was seen on the 2nd March 2015 the community nurse was advised

	by the deceased that no appointment at the 'hot foot' clinic had been received. The nurse telephoned the clinic that same day and was advised the earliest appointment available was 17th March 2015. On 12th March 2015 the deceased was attended by the tissue viability link nurse from the NSCP who noted high levels of exudate and was malodorous. Visits were increased to three times a week. By 14th March 2015 the community nurse noted that the ulcer had increased in size. There was also exudate and the wound was still malodorous. On 16th March 2015 the deceased attended Weston General Hospital for a session of dialysis. She was unwell at the dialysis unit and was admitted to the Emergency Department of Weston General Hospital that same day. She was seen by the tissue viability nurse who noted the whole of the foot to be gangrenous, necrotic and malodorous. The toes were discoloured and there was an excessive amount of macerated, loose skin. The deceased was transferred that same day to Southmead Hospital, Bristol under the care of the vascular surgeons. She was commenced on antibiotics but it was determined that amputation of the limb was necessary. The initial operation was performed on 19th March 2015. The deceased required further surgery and returned to theatre on 22nd March 2015. Unfortunately following the second operation her condition deteriorated and she died that same day.
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) An urgent referral was made by the community nurses to the 'hot foot' clinic on 26th February 2015 and no appointment could be offered until 17th March 2015. (2) Before this appointment date the deceased's ulcer had deteriorated and she had been admitted to hospital where she later died. (3) There should be a review of the means by which patients who are referred to this clinic are prioritised. (4) There should a review of the resources allocated to this clinic in the light of demand from new and follow-up patients. (5) The NSCCG should collaborate with Weston Area Health Trust and other relevant stakeholders to ensure current and future resources are used efficiently and effectively. (6) There should be provided guidance to those who refer patients to this clinic with regard to referring patients to this clinic and other options for assessment and treatment as well as a standardised means of referral so that all patients are prioritised according to clinical need.
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 8th April 2016. 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 [redacted] sister of the deceased, the Weston Area Health NHS Trust and North Somerset Community Partnership.

I shall send a copy of your response to [redacted], the Weston Area Health NHS Trust and the North Somerset Community Partnership.

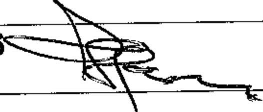
I have sent a copy of my report to the Chief Coroner.

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.was under 18)]. I have also sent it to [NAMED PERSON] who may find it useful or of interest.

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	**12th February 2016** 	**Assistant Coroner**