Ms N J Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Dr Navjot Ahluwalia - Medical Director** Rotherham, Doncaster and South Humber NHS Foundation Trust, Woodfield House, Trust Headquarters, Tickhill Road, Doncaster DN4 8QN
1	**CORONER** I am Ms N J Mundy, Senior Coroner for South Yorkshire (East District)
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 13/04/2016 I commenced an investigation into the death of Jane Bulloch Wilson Stables, 70. The investigation concluded at the end of the inquest on 15 December 2016. The conclusion of the inquest was a Narrative conclusion. The cause of death was: 1a. Sepsis 1b. Pressure Ulceration of skin, 1c. Immobility from Rheumatoid Arthritis, 2. Ischaemic heart disease, frailty, malnourishment.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Stables had a long history of severe rheumatoid arthritis treatment for which was limited due to her morbid fear of hospitals to the extent that she declined to attend for consultations. The disease progressed and by the end of 2015 she was in considerable pain with contractures and had become bed bound. District nurses were visiting regularly, their visits were increased. She also had carers attending four times a day. The evidence I heard from the district nurses, tissue viability nurse and the carers was entirely consistent with regard to the extent of Mrs Stables pain and challenges this presented in providing her with care and repositioning her as required. The pain was never properly controlled and thus she was caused severe pain when care was delivered. In spite of this there was a failure on the part of the nurses and carers to effectively communicate those concerns with the General Practitioner which would have enabled further pain relief reviews to have taken place and thus the possibility of enhanced pain relief which would have more effectively managed that pain. In addition, the district nurses put in place a care plan for regular turning and that she was to be repositioned on each of the four attendances that the carers made each day. Despite this, the turns were not carried out as directed, the documentation regarding turns and repositioning is lacking and on some days there appeared to be no repositioning at all. From the 14th March to the 21st March the notes are particularly scant with regard to repositioning and turns and by the 21st March the community staff nurse was so concerned that the advice to regular turn had not been followed that she raised this again with [redacted] left a note for the carers and also left repositioning charts. From that point on there was increased frequency in turns and recording of the same but the back area on the coccyx noted on the 16th March together with the other pressure sores had significantly deteriorated and my conclusion is that a contributory factor was the failure to adhere to the care plan and in particular the turns required under that plan. On the 30th March Mrs stables was admitted to the Doncaster Royal Infirmary as an emergency and she passed away there on the 2nd April 2016.
5	**CORONER'S CONCERNS**

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	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)** Ineffective communication between the nurses and general practitioner regarding ongoing significant pain levels which were impeding care provided.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted] Medical Director, Rotherham, Doncaster and South Humber NHS Foundation Trust 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 09 February 2017. 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] Doncaster Royal Infirmary Legal Services Department. 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 15 December 2016 Signature pp NJ Mundy Senior Coroner for South Yorkshire (East District)