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:** Mr Andrew Foster, Chief Executive, The Wrightington, Wigan and Leigh NHS Foundation Trust, The Elms, Royal Albert Edward Infirmary, Wigan Lane, Wigan WN1 2NN.
1	**CORONER** I am Alan Peter Walsh, HM Area Coroner for the Coroner Area of Manchester West.
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 25th October 2016 I commenced an Investigation into the death of Patricia Forshaw, 73 years, born on the 27th July 1943. The Investigation concluded at the end of the Inquest on the 21st August 2017. The medical cause of death was:- Ia Sepsis Ib Infected Wound in Right Lower Leg The conclusion of the Inquest was Patricia Forshaw died as a consequence of injuries sustained in an accidental fall where vital observations and further investigations were not conducted following a deterioration in her condition arising from a developing infection.
4	**CIRCUMSTANCES OF THE DEATH** 1. Patricia Forshaw (hereinafter referred to as "the deceased") died at The Royal Albert Edward Infirmary, Wigan on the 22nd October 2016. 2. On the 19th October 2016 the deceased fell in her garden at her home address at [redacted] sustaining a full thickness wound to her right leg. She was taken to The Royal Albert Edward Infirmary, Wigan, where the wound was treated with steristrips and a dressing and she was discharged to attend an Out Patient Clinic at the Hospital on the 21st October 2016. The only documentation given to the

Deceased when she was discharged from the Hospital was a card showing the date of the Out Patient appointment and a telephone number.

3. In view of the pain experienced by the deceased, the deceased's husband telephoned The Royal Albert Edward Infirmary, Wigan, in the early hours of the 20th October 2016 using the telephone number on the card given to the deceased when she was discharged from the Hospital.

   The deceased's husband believed that he spoke to someone in the Emergency Department at the Hospital and he was advised to give the deceased paracetamol to relieve her pain. The telephone call and the advice given to the deceased's husband were not recorded in the Hospital records.

   Later the same day the deceased's husband telephoned the General Practitioner in relation to the pain experienced by the deceased and the General Practitioner issued a prescription for Tramadol, as additional analgesia.

4. On the 21st October 2016 the deceased's leg became swollen and there was a discharge from the wound with a very offensive smell. The deceased attended the Out Patient appointment at the Royal Albert Edward Infirmary, Wigan an hour earlier than the scheduled appointment because she was in substantial pain. When she arrived at the Hospital, with her husband and daughter, she asked if there was a Triage Nurse available to examine the wound but she was told that a Triage Nurse was not present on the Unit and she would have to wait for the scheduled time of the appointment.

   Whilst waiting in the waiting area the deceased complained of feeling cold and she was provided with a blanket by a Nurse.

   When the deceased was seen by a Nurse to remove the dressing prior to the consultation with a Doctor, the family told the Nurse of the obvious offensive smell from the wound and the Nurse said that it was an infection in the wound. The Nurse did not make a note of the offensive smell, the discharge from the wound or the infection in the wound and the Nurse did not bring those matters to the attention of the Doctor when he saw the deceased.

   [redacted] saw the deceased and noted a description of the wound and swelling around the wound, together with redness to the skin overlying the tibia bone of the leg but he did not note the discharge. The Doctor further noted that there were signs suggesting that the wound was becoming infected and the wound was re-dressed. The Doctor prescribed Clarithromycin, as an antibiotic, and he arranged a further review appointment four days later. No routine observations (pulse, blood pressure, respiratory rate, temperature) were taken and no blood samples or blood cultures were arranged.

5. When the deceased returned home from the Out Patient appointment, she continued to experience substantial pain with an increased amount of offensive smelling discharge from the wound. Accordingly, on the 21st

October 2016 the deceased's son telephoned the Emergency Department at the Royal Albert Edward Infirmary, Wigan, asking whether he could take the deceased back to the Hospital, emphasising his concern about the severity of his mother's condition and the amount of offensive discharge from her leg. He was told that the Hospital would only re-dress the leg and he would be better taking his mother to the General Practitioner to arrange support from the District Nursing Service.

The deceased saw the General Practitioner later the same evening he and prescribed additional anti biotics with a referral to the District Nursing Service to attend the deceased on the following day.

6. At or about 04:00 hours on the 22rd October 2016 the deceased suffered a cardiac arrest at her home address. She was taken to the Royal Albert Edward Infirmary, Wigan where, in spite of resuscitation attempts, she died a short time after arrival at the Hospital.

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. During the Inquest evidence was heard that:-

   i. The telephone number on the card given to the deceased when she was discharged from the Hospital related to appointments only but the purpose of the number is ambiguous and when the deceased's husband telephoned the number on the card in the early hours of the 20th October 2016 he believed he was speaking to the Emergency Department, particularly in view of the fact that he was given advice to give paracetamol to the deceased.

   Evidence was given at the Inquest that the appointment card was the only documentation given to the deceased when she was discharged and the card does not have any information as to the action to be taken if there is a deterioration in a patient's condition after discharge. The evidence given by [redacted] a Consultant in Emergency Medicine at the Hospital was that if there is a deterioration in condition the patient should not be given treatment advice by telephone and the patient should be advised to telephone 111 or return to the Hospital but [redacted] accepted that there is no reference to such action on the card.

   ii. The telephone call from the deceased's husband to the Hospital in the early hours of the 20th October 2016 and the advice to give paracetamol was not recorded in any Hospital records.

   Furthermore, the consultation with the Nurse who removed the dressing and who was aware of the deceased requiring a blanket because she was

cold and also aware of the offensive smelling discharge from the wound, did not record that information in the notes and did not bring the information to the attention of the Doctor at the time of his consultation with the deceased.

The evidence at the Inquest indicated that the nurse would not be expected to make a note relating to the above information but she would be expected to mention the information to the Doctor.

[redacted] commented in his evidence that there had been a "gross miscommunication" in the care of Mrs Forshaw.

iii. [redacted] accepted that, having heard the evidence of the family at the Inquest, routine observations (pulse, blood pressure, respiratory rate, temperature) and blood investigations should have been conducted when the deceased presented to the Out Patient appointment on the 21st October 2016. [redacted] gave evidence that there had been some discussion between Consultants in the Emergency Department and there was mention that there should be a policy for checking routine observations in patients attending Clinic for wound review, particularly where there was an indication of infection. However [redacted] confirmed that there was no formal policy in place.

iv. The evidence at the Inquest confirmed that there had been a discussion between Consultants in the Emergency Department in relation to the treatment and care of Mrs Forshaw but the treatment and care of Mrs Forshaw had not been escalated as a formal report for consideration of a Serious Incident Review. Accordingly, a Serious Incident Review had not taken place in relation to Mrs Forshaw's death, although it was accepted that, in retrospect, a Review should have taken place to enable any recommendations to be formalised within the Governance framework.

2. I request you to conduct a review of the policies, procedures and protocols in relation to the following matters:-

i. The information on the appointment cards, particularly in relation to the identification of unambiguous telephone numbers together with advice as to the action to be taken when a patient deteriorates with consideration of "telephone 111 or return to the Hospital".

ii. The notes to be recorded by Nurses, either in relation to telephone calls made to the Hospital by or on behalf of a discharged patient or in relation to Nurses conducting a preliminary examination prior to consultation with a Doctor to ensure that the notes are available to the Doctor when the Doctor conducts an examination and an assessment.

iii. Routine observations and blood investigations in relation to patients attending the Hospital, particularly the Emergency Department or Out Patient Clinic, where there is evidence and diagnosis of a wound infection.

	v. The reporting and escalation of incidents in the Emergency Department leading to consideration of a Serious Incident Review and appropriate action within the Governance framework.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 Friday 3rd November 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:- 1. [redacted] Mrs Forshaw's daughter in law, [redacted] 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** **8th September 2017**
	Signed **Alan P Walsh** **HM Area Coroner**