REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Milestones Trust** **THIS REPORT IS BEING COPIED TO:** 2. [redacted] **sister of the Deceased** 3. **Care Quality Commission** 4. **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 27th June 2016 I commenced an investigation into the death of Ms. Sandra Miller age 55 years. The investigation concluded at the end of the inquest on 24th January 2018. The conclusion was that the medical cause of death was I(a) Pneumonia; II E. coli septicaemia due to a urinary tract infection. Heart failure. The conclusion as to the death was: The Deceased died of pneumonia contributed to by heart failure and E. coli septicaemia consequent upon a urinary tract infection.

4	**CIRCUMSTANCES OF THE DEATH**

The deceased suffered with Down's syndrome, Alzheimer's disease, hypothyroidism, type II diabetes mellitus and she had an epigastric hernia. She had impaired swallowing and on occasion suffered with aspiration pneumonia.

In May 2015 she was discharged from hospital to reside at Mortimer House Nursing Home, Bristol, which is owned and managed by the Milestone Trust. On discharge from hospital she had a urinary catheter due to a voiding dysfunction. This voiding dysfunction was considered to be related to her neurological condition. She was also incontinent of faeces. At a Best Interests Meeting held on 20th August 2015 it was determined that owing to Ms. Miller becoming distressed and agitated at the time when her urinary catheter was changed it was agreed that she could be sedated for this procedure. Removal of the catheter was considered but when removed on previous occasions she had gone into urinary retention. Therefore it was planned to refer her to the urologist for further advice.

She was seen on 15th September 2015 by [REDACTED] Consultant Urological Surgeon. Ms. Miller would become agitated and try to remove or pull at the urine bag. As a result it had become practice at Mortimer House to remove the bag and tubing and allow the open catheter to drain freely on to a pad. In his letter of 30th September 2015 to the GP and copied to Mortimer House [REDACTED] noted that this practice meant that there was an open system from the outside world to the bladder which would increase her risk of infections and that this practice should not be continued. He recommended the use of a flip-flow valve if a bag could not be used and if that was not successful to consider a suprapubic catheter. The GP in evidence stated that the GP records indicate the advice given to the staff at the home was to try the flip-flow valve.

A copy of this letter was date stamped as being received at Mortimer House on 15th October 2015. However, in evidence the Assistant Home Manager stated that letter had not been seen by her or her colleagues and therefore the recommendations of [REDACTED] were not acted upon. Consequently the practice of leaving the urinary catheter on free drainage continued.

In evidence the Assistant Home Manager further stated that Ms. Miller, who was incontinent of faeces, wore incontinence pads, and the open end of the catheter was 'tucked inside' this incontinent pad and the pad changed four times daily. Therefore the open end of the catheter was in contact with, or close to, any faeces.

On 15th June 2016 Ms. Miller became unwell and she was attended urgently by an Emergency Care Practitioner from the out-of-hours GP service. He assessed her as suffering with sepsis probably due to pneumonia or possibly a urinary tract infection. Ms. Miller was admitted as an emergency by ambulance to Southmead Hospital, Bristol.

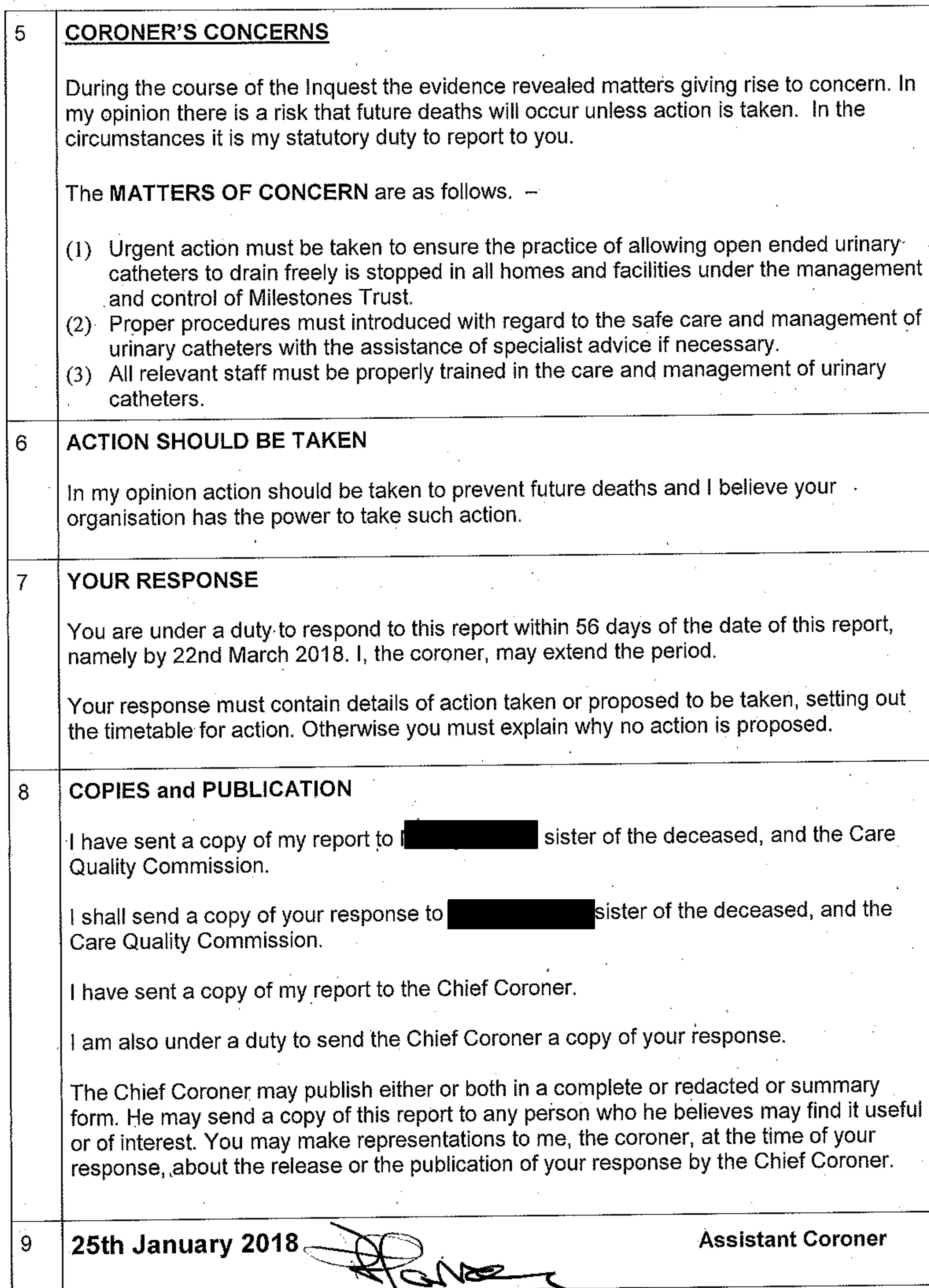
The Staff Nurse in the Emergency Department observed the catheter to not be connected to a bag nor was a spigot fitted. In evidence the Staff Nurse stated the tip of the catheter was dirty. On removing the catheter a large quantity of foul smelling, pus-like urine drained from the bladder suggesting the catheter had been blocked.

Investigations revealed she was suffering with a respiratory and / or a urinary tract infection and heart failure. She was treated for sepsis and blood cultures later revealed she had an E.coli septicaemia.

Notwithstanding appropriate antibiotic therapy Ms. Miller's condition declined and she died in hospital on 21st June 2016. The primary cause of her death was considered to be pneumonia.

At the Inquest the Area Manager of Milestones Trust, a registered nurse, who conducted a review in advance of the Inquest could not confirm that action had been taken to stop

this practice of leaving a urinary catheter to free drainage; that proper procedures had been implemented, and that staff had received any necessary training.



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) Urgent action must be taken to ensure the practice of allowing open ended urinary catheters to drain freely is stopped in all homes and facilities under the management and control of Milestones Trust.
(2) Proper procedures must introduced with regard to the safe care and management of urinary catheters with the assistance of specialist advice if necessary.
(3) All relevant staff must be properly trained in the care and management of urinary catheters.

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 22nd March 2018. 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, and the Care Quality Commission.

I shall send a copy of your response to [redacted] sister of the deceased, and the Care Quality Commission.

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.

9 25th January 2018 **Assistant Coroner**