Regulation 28: Prevention of Future Deaths report

John William Pearce (died 21.9.2018)

	THIS REPORT IS BEING SENT TO: **Ms Claire Murdoch** **Chief Executive** **Central & North West London Foundation Trust** **350 Euston Road** **London NW1 3AX**
1	**CORONER** I am: Edwin Buckett Assistant Coroner Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, Regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 23rd October 2018 Senior Coroner Hassell began an investigation into the death of John William Pearce who died aged 90 on the 21st September, 2018 at University College Hospital, London. The investigation concluded at the end of the inquest on 25th February 2019, conducted by myself, Assistant Coroner Edwin Buckett. I made a determination at inquest that the deceased died as a result of a sepsis which was caused by osteomyelitis which in turn was caused as a result of a left knee wound, sustained as a result of an accident in April, 2018.
4	**CIRCUMSTANCES OF THE DEATH**

1. The deceased was a frail 90 year old man with a past medical history of hypertension, COPD, alcohol dependence and falls. He was chair/bedbound, lived alone and had carers attending on him 4 times a day with the District Nurse team attending on him regularly.

2. On a date in April, 2018 he sustained an injury to his left knee which somehow came into contact with a metal safe in his property.

3. On the 20th July, 2018 he was admitted to University College Hospital where a wound to that knee was identified but it did not appear infected and X-rays taken at the time did not suggest osteomyelitis.

4. The deceased was discharged from hospital case on 21st July, 2018 and seen by the NHS Trust District Nursing team for a period of about 2 months until he was re-admitted to hospital on the 15th September, 2018.

5. During the course of that 2 month period, the District Nurse team recorded his left knee wound as increasing in size and debriding. Photographs taken of that wound on various dates leading up to the 24th August, 2019 revealed a very severe knee injury.

6. The last Tissue Viability Nurse to attend on the deceased was on the 24th August, 2018. His left knee wound was identified as deep dermal, debriding and necrotic.

7. On the 15th September, 2018 the deceased was taken to hospital where he was recorded as having a Grade 4 ulcer to the left knee. X-rays taken on admission indicated suspected osteomyelitis.

8. The deceased's condition deteriorated and he died in hospital on the 21st September, 2018.

9. The Post Mortem report in this case confirms that that trigger for the ultimate cause of death was ulceration/pressure sores and that sections of the patella from the left knee showed inflammatory infiltrate in keeping with osteomyelitis.

10. I found that the source of the cause of death was the left knee injury which worsened significantly in the 2 months before his death.

	11. It is clear to that he should have been admitted to hospital far earlier than the 15th September, 2018 and that earlier treatment of his knee injury may have prevented his death, notwithstanding his co-morbidities and advanced age. 12. I was not able to conclude that earlier intervention would have, on the balance of probabilities, saved or prolonged life but the evidence in the case came very close to a conclusion of that nature.
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. Evidence was given by medical staff from the District Nursing Team of the Central and North West London NHS Foundation Trust: 1. Staff from the District Nursing Team (Nurses, HCAs, Tissue Viability Nurses and Nursing Assistants) attended on Mr Pearce at his home address fairly regularly between 21.7.2019 and the 15.9.2018. 2. On many of those visits photographs and measurements of his left knee wound were taken; 3. The condition of that wound severely worsened during this 2 month period to such an extent that tendons and bone were visible yet he was never urgently referred to hospital until carers (who provided a separate care service to the Trust) contacted the emergency services on the 15th September, 2018. 4. The Post Mortem examination of Mr Pearce revealed (inter alia) that the left knee included (a) a wound which measured 12 x 7.5cm exposing the patella, and (b) ulceration exposing the tendon measuring up to 7cm. 5. Despite the clear and obvious worsening condition of his left knee, the deceased was last seen by a Tissue Viability Nurse on the 24th August, 2018. The left knee would was seen by a nurse who attended on Mr Pearce on the 20th August, 2018 who described it as "really bad".

	I am concerned that: (a) There was no clear instruction, protocol or system which assists nursing staff in dealing with elderly patients who suffer from open wounds which worsen over time, as to when the emergency services should be contacted. It is clear that the staff were following a Tissue Viability Nurse care plan, but no-one appeared to recognise the severity of the injury and the fact that tendons and bone were exposed; (b) There were insufficient attendances on Mr Pearce by the District Nurse Team when it appeared to be decided that he would be visited at more frequent intervals; (c) Too much emphasis was placed on Mr Pearce's own view that he did not like hospitals and did not want to go there, even though he was noted to be an individual who had difficulty expressing himself; (d) There was no clear evidence that photographs taken of the wound were shared with other agencies or the deceased's GP, such that another view could be taken of those wounds so as to consider whether the emergency services should become involved as a matter of urgency.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and/or your organisation 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 **24th April 2019**. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales

	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	**DATE 25.2.2019 SIGNED BY ASSISTANT CORONER EDWIN BUCKETT**