REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Jeanette Ann Robinson, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Service Director, Transformation and Commissioning, Adult Social Care and Health, Cornwall Council** **2. [redacted], Medicines and Healthcare Products Regulatory Agency, 10 S. Colonnade, Canary Wharf, London E144 PU**
1	**CORONER** I am Mr Andrew Cox, Acting Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 5/1/17, an inquest was opened into the death of Jeanette Ann Robinson who died on 21/12/16 at Royal Cornwall Hospital Truro. At post-mortem, the cause of death was identified as: 1A) systemic sepsis (coagulase-negative staphylococcus and mixed anaerobic organisms) 1B) infected sacral decubitus ulcer (operated) 1C morbid obesity and diabetes mellitus (type II) II) frailty On 24/5/19, I concluded an inquest into the death of Mrs Robinson and recorded a narrative conclusion namely, that she died as the result of an accident. An unsuccessful attempted transfer into a community hospital contributed to the outcome.
4	**CIRCUMSTANCES OF THE DEATH** I found that Mrs Robinson was a lady with a number of health issues that included morbid obesity and type II diabetes mellitus. She suffered a fall on or about 30/10/16 which reduced her already limited mobility. There was a delay in referring her to the district nurse team. Mrs Robinson developed a sacral pressure ulcer in early December 2016. A specialist mattress designed to relieve pressure to vulnerable areas was found to be accidentally deflated on 12/12/16. This caused a significant worsening in the condition of the wound. An attempt was made to admit Mrs Robinson into St Austell community hospital on 16/12/16 but this failed due to the wrong form of conveyance being organised. Mrs Robinson was admitted, in a septic condition, into Treliske hospital on 19/12/16. Despite further treatment, she deteriorated and died in the hospital on 21/12/16.
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: Mrs Robinson was using a nimbus 3 air mattress and a Toto (electronic turning device) at the time the mattress was found to be accidentally deflated. The mattress became deflated when the power cable into the pump was dislodged. I understand there was no alarm fitted to the system or any other warning to alert Mrs Robinson to the developing problem. I understand that you are the director with responsibility for the equipment loan service in Cornwall. I do not know whether this was an isolated incident or part of a bigger concern but given the significant contribution the failure of the device had in terms of its contribution to Mrs Robinson's death, I felt it appropriate to bring the incident to your attention.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. You will be aware whether this incident may properly be regarded as a "one-off" or, alternatively, this is a product where there is an ongoing concern that similar deaths may arise in the future unless action is taken. It would seem to be a relatively simple matter to install an alarm or other warning to a user that a particular mattress is becoming deflated.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1/8/19. 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 family of Mrs Robinson. I have also sent it to the MHRA 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	**[DATE]** **[SIGNED BY CORONER]** **03.06.2019**