Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:
The Chief Executive
Queen Elizabeth Hospital
Gayton Road
King's Lynn
Norfolk
PE30 4ET

1 CORONER

I am Jacqueline LAKE, Senior Coroner for the area of Norfolk

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 06/02/2019, I commenced an investigation into the death of Carol Anne JENNINGS aged 79. The investigation concluded at the end of the inquest on 01/08/2019. The conclusion of the inquest was: Natural causes. The medical cause of death:

1a Septicaemia
1b Infected Leg Ulcers, Hospital Acquired Pneumonia
1c
II Chronic Kidney Disease

4 CIRCUMSTANCES OF THE DEATH

Mrs Jennings had a number of comorbidities including lymphedema, bilateral venous leg ulcers and chronic liver disease. She had several admissions to hospital due to infections. Mrs Jennings was admitted to Queen Elizabeth Hospital on 10 January 2019 due to high potassium levels. Mrs Jennings was referred to the Tissue Viability Nurse on 12 January 2019 but was not seen. She was started on antibiotics on 15 January 2019 and considered for discharge on 18 January 2019 but then remained in hospital. On 21 January 2019, Mrs Jennings legs were examined and considered to have infected leg ulcers and IV antibiotics started. She was reviewed on 23 January 2019 and no infection of the ulcers was noted. Mrs Jennings' condition deteriorated, and she was started on end of life care on 25 January 2019 and she died on 31 January 2019.

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. Mrs Jennings was referred to the Tissue Viability Nurse by way of a message being left on a telephone answering machine due to her legs being "red" and "wet" on 12 January 2019. As there was no mention of an "open wound" in the telephone message, no action was taken by the Nurse and the referral was not chased up by the ward. A second referral was made on 21 January 2019 by a different doctor. In evidence the Nurse reported as having too many referrals and not having time to deal with them all. At the resumed inquest evidence was heard that referral by electronic means is being considered which would assist in ensuring consistent and relevant information being provided and an audit trail of referrals and further investigation/patients seen. This is a relatively straightforward system to implement but there is no timescale in place for it to be implemented.
2. The evidence revealed a lack of and/or inadequate record keeping. Mrs Jennings was admitted to hospital on 10 January 2019 and there is no detailed record describing the wound until 21 January 2019 and no measurement of the wound until 23 January 2019. There are no photographs of the wound. A wound assessment form was not completed. At the resumed inquest no steps had been taken to ensure full and proper record keeping.

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 27 September 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 Chief Coroner and to the following Interested Persons:

Mr Paul Jennings and Mr Christopher Jennings - sons

I have also sent it to:

Department of Health
CQC
HSIB
Healthwatch Norfolk

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 Dated: 02/08/2019

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Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich NR1 2TN