HM Coroner
Manchester South

Chief Coroner's Office

Via email: rule43reports@justice.gov.uk

16th December 2019
Our Ref: 12108/CH

Dear Sirs

RE: **Arnold Fletcher WARD**

I enclose herewith a copy of the Regulation 28 Report I have today sent to the Registered Manager of Fernlea Nursing Home, the Chief Executive of the Care Quality Commission and the Accountable Officer of Stockport Clinical Commissioning Group (CCG).

I will forward a copy of the response in due course.

Yours faithfully

Alison Mutch OBE
HM Senior Coroner

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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Registered Manager of Fernlea Nursing Home, Chief Executive of Care Quality Commission and the Accountable Officer of Stockport Clinical Commissioning Group (CCG).
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 21st January 2019 I commenced an investigation into the death of Arnold Fletcher Ward .The investigation concluded on the 4th December 2019 and the conclusion was one of **Narrative: Died from natural causes exacerbated by the complications of a grade four pressure sore, not escalated to the Tissue Viability Team when it showed clear signs of deterioration.** The medical cause of death was **1a) Acute Myocardial Infarction; 1b) Heart Failure; II) Chronic Sacral Osteomyelitis secondary to a grade four pressure ulcer, previous Cerebrovascular Infarctions, Hospital Acquired Pneumonia**
4	CIRCUMSTANCES OF THE DEATH Arnold Fletcher Ward was at high risk of pressure ulcers. He was resident at Fernlea Nursing Home. On 25th October 2018 a request was sent for Tissue Viability Nursing Team (TVN) input because he had a developing sacral pressure ulcer. No response was received and there was no follow up by the home until a further request was made on 19th December 2018. In the intervening period, it was deteriorating with an odour being present from November 2018. No clear records or photographs were taken to track the deterioration. On 21st December a Tissue Viability Nurse identified it as a grade 4 pressure ulcer

	and put an immediate plan in place. On 24th December an x-ray arranged by the Tissue Viability Nurse identified osteomyelitis and he was admitted to Stepping Hill Hospital, and treated. On 21st January 2019 whilst an inpatient, he died from a myocardial infarction.
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. – The inquest heard that within the home the forms used did not capture the deterioration of the pressure ulcer or require detailed monitoring/use of photographs to track its progress. This meant that the significant and steep deterioration was not recognised and escalated at an early opportunity to the Tissue Viability Nursing team for expert wound management input. As a result the type of wound dressings he required were not utilised/available. It had been captured in the notes that there had been a referral to the Tissue Viability Nursing team in October. There was no system in the home to chase up the team after a number of weeks had elapsed and there had been no response. The inquest heard that even in non-urgent cases the Tissue Viability Nursing team would contact a home requesting support in at least 10 days and more quickly in an urgent case.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe 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 10th February 2020. 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 namely 1) Mrs Woodside on behalf of the family; 2) Stockport Metropolitan Borough Council, 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	**Alison Mutch OBE** **HM Senior Coroner** **16.12.2019**