REGULATION 28 REPORT

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Shrewsbury and Telford Hospital NHS Trust**
1	**CORONER** I am Mrs Joanne Lees Assistant Coroner for **Shropshire, Telford & Wrekin**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17/07/2019 I commenced an investigation into the death of Peter SUDLOW. The investigation concluded at the end of the inquest 17th January 2020. The inquest concluded with a narrative conclusion as follows; The deceased died from a naturally incurring infection of a pressure sore which originated during a hospital stay following a prolonged period of immobility on a background of ischaemic myelopathy and profound persisting paraplegia. My findings as recorded in box 3 were as follows; Between 23/1/19 and 23/2/19 the deceased was a hospital inpatient having been diagnosed with ischaemic myelopathy with paraplegia. During his stay on the ward he developed a sacral tissue injury which developed to at least a grade 2 pressure sore. On 23/2/19 he was discharged to a nursing home where the pressure sore deteriorated and became infected. Despite antibiotics the deceased continued to deteriorate and was readmitted to hospital on 16/3/19 at which point the infected sacral pressure sore had become necrotic and developed to grade 4. Despite an initial improvement the deceased was placed on palliative care and discharged to a hospice where he later sadly passed away on 8/4/19. It is likely that the sacral pressure ulcer was more than a grade 2 at the time of discharge but deteriorated to ungradable whilst at the nursing home despite appropriate preventative and management measures being undertaken.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted in January 2019 to hospital following sudden onset of weakness in both legs and diagnosed with Ischaemic Myelopathy and paraplegia. On the ward he developed a sacral would than developed into a pressure sore. He also developed pressure damage to his heels. After approximately one month he was discharged to a nursing home where he was found to have a significant sacral pressure ulcer which was classified as ungradable by the nursing home. The nursing home contacted Tissue Viability Nurse and Safeguarding in relation to the pressure sore due to concerns. The deceased deteriorated, the pressure sore became infected and despite antibiotics the deceased continued to deteriorate, and he was admitted back to back to hospital on 160319 with infected pressure sore (blood cultures were positive). His prognosis was discussed with Vascular surgeons who deemed surgery not an option due to depth of sore. IV antibiotics given with no improvement. Best supportive care decided with family and discharged to Hospice and he sadly passed away in the hospice on 8/4/19.
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) During the period of time the deceased spent in hospital between 23/1/19 and 23/2/19 there was no referral to the Tissue Viability Nurse (TVN) at any time. (2) There was no referral to the TVN when the sore was categorised as a grade 2. (3) There was no referral to the TVN when the Waterlow score of the deceased increased to 17. (4) There was no referral to the TVN when the deceased was readmitted to hospital on 16/3/19 and the pressure sore determined to be Grade 4 until 22/3/19. (5) There was no clear guidance as to when and in what circumstances a referral to the TVN should be made. (6) The deceased presented with additional risks as determined by the Waterlow score with paraplegia and there was no clear guidance as to when a TVN referral should be made for those patients with additional risks such as paraplegia or neurological deficit for the purpose of seeking advice as to the prevention of pressure sores. (7) There was no clear guidance as to the involvement of the TVN in developing a plan to prevent pressure sores in those patients presenting with additional risks such as paraplegia or a neurological deficit. (8) There was no clear guidance as to the relationship between the determination of the Waterlow score and referral to the TVN to assist nursing staff. (9) The new Pressure Ulcer Prevention and Treatment 2 week booklet (PUPT) makes no reference to a TVN referral until a pressure ulcer has reached Category or Grade 3.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you **The Shrewsbury and Telford Hospital NHS Trust** 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 17/3/20. 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 [redacted] (daughter of the deceased) and Morris Care Limited. 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	17/01/2020 Signature  Mrs Joanne Lees Assistant Coroner **Shropshire**, **Telford & Wrekin**