REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Owner and Manager Jubilee Court Nursing Home** **2. Care Quality Commission**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 5thMarch 2020 , I commenced an investigation into the death of Norma Lockton, aged ninety years. The investigation concluded at the end of the inquest on the 18th December 2020. The conclusion of the inquest was a Narrative Conclusion as follows: Norma Lockton was a resident at Jubilee Court Nursing Home. She was a vulnerable frail woman of 90 years, subject to a Deprivation of Liberty Safeguard Order at the time of her death. Norma was found in early February 2020 to have vulnerable skin pressure areas, and increasing contractures of her knees, with reduced mobility. She was seen by a district nurse on the 8th and 9th February 2020, and a clear regime set out, written down, and given to care staff, to prevent pressure damage to Norma's skin. These instructions were not followed and Norma developed a deep wound behind her left knee, because the bandage and pressure relieving pad were not changed regularly, nor washed regularly, and the area of skin under the bandage was not checked regularly. Norma developed cellulitis of her leg as a result of this wound becoming infected on 29.2.20. The cellulitis was not recognised to have developed as a result of the wound, nor was it recognised as a serious and life threatening condition. No medical assistance was called for Norma until she had advanced cellulitis, and systemic sepsis, by which time, antibiotic and fluid treatment was ineffective. Norma died in Bassetlaw Hospital, Worksop, Nottinghamshire on the 4th March 2020. Norma would on a balance of probability have survived, had the skin care instructions given by the District nursing team been followed. Her death was contributed to by Neglect.
4	**CIRCUMSTANCES OF THE DEATH** Norma, whilst having some health issues, was in reasonable physical health for her age until late February 2020. She had become less mobile with increasing stiffness and pain in her legs in early February. She was dependant on care staff for all her personal care and mobility needs. She was at increased risk of skin damage as her mobility reduced, and she was seen by the District nurse team. They organised a plan to protect her vulnerable skin areas, and this was not followed by the care staff.

	A wound developed behind her left knee that was not noticed by care staff. It led to cellulitis and systemic sepsis and her death. The cellulitis was not recognised as a serious condition for two to three days, and therefore no medical assistance was sought. There was also no regular repositioning of Norma.
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. The lack of an updated skin integrity care plan, with little understanding by the management as to why there had been no update to it following the clear District Nurse instructions regarding skin care. 2. The lack of regular documented repositioning of Norma, with no understanding by the management team as to how and why this issue had occurred. 3. The lack of recognition of Norma's changing health and mobility needs, leading to no change in her general health and mobility care plans 4. The lack of recognition of a serious and deteriorating medical condition (that of cellulitis), leading to no medical assistance being organised until the situation was life threatening. 5. The lack of robust review by the management team following a death.
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 the 16th March 2021. 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. For the avoidance of doubt, I will require a response from Jubilee Court Care Home only. I would also expect the CQC to visit, and update me as to their findings and any action taken
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. [redacted] family of Norma Lockton 2. Nottinghamshire County Council 3. Nottinghamshire Healthcare NHS Foundation Trust 4. East Midlands Ambulance Service NHS Foundation Trust 5. Doncaster and Bassetlaw Hospitals NUHS Foundation Trust 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	**16th January 2021** **Dr E A Didcock**