Regulation 28: Prevention of Future Deaths report

Cecilia EDWARDS (died 08.10.20)

	THIS REPORT IS BEING SENT TO: **1. Dr [redacted]** **Executive Medical Director** **Whittington Health NHS Trust** **Whittington Hospital** **Magdala Avenue** **London N19 5NF**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 4 November 2020, I commenced an investigation into the death of Cecilia Edwards, aged 91 years. The investigation concluded at the end of the inquest on 18 February 2021. I made a determination of death by natural causes. The medical cause of death was: 1a Citrobacter koseri pneumonia and infected pressure sore of the right elbow complicating with osteomyelitis 1b immobility and malnutrition 1c end stage dementia 2 general frailty
4	**CIRCUMSTANCES OF THE DEATH**

	Cecilia Edwards was admitted to the Whittington Hospital on Saturday, 26 September 2020 generally unwell, with a severe right elbow infection. She deteriorated and died in hospital two weeks later.
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. District nursing care was provided by Whittington Health. 1. On 12 February 2020, a district nurse assessed Ms Edwards' elbow as a category 3 pressure ulcer, which should have prompted an immediate referral to the tissue viability nurse. However, no such referral was made, either by the attending nurse; the district nurses who visited twice a week over the next seven months; the frequent care plan reviewers; or the shift co-ordinator until 22 September 2020. 2. 60% of the district nurses who visited Cecilia Edwards were agency nurses. This is obviously undesirable in itself, although I recognise that it may be very difficult to address. That notwithstanding, the district nurse team manager giving evidence in court agreed with Ms Edwards' niece (herself a former district nurse and health visitor, and her auntie's longstanding advocate) that clear protocols would raise standards, make mistakes less likely and bring the agency staff in as part of the organisation. Ultimately this would improve patient care. 3. The district nurses who visited Cecilia Edwards needed the assistance of the two carers to turn her and attend to all her nursing needs, but sometimes when they visited there were no carers present and so the nursing care given was incomplete. The carers attended at set hours four times a day, and so it seems that the onus was on the nursing team to arrange the twice weekly visits appropriately. Sometimes, individual nurses would ring individual carers to make arrangements, but there was no organisational system to ensure that nurse and carer visits coincided as a matter of routine.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 19 April 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following. • [redacted], niece of Cecilia Edwards • SureCare – provider of carers • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 22.02.21 *ME Hassell*