REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Rt Hon Savid Javid MP** **Secretary of State and Social Care** **Department of Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 5th March 2020 I commenced an investigation into the tragic death of **Roland STANNARD** The investigation concluded at the end of the inquest on 12th August 2021. The conclusion of the inquest was that:- **Roland Stannard died as the result of a serious infection caused by a sacral sore.** **This sacral sore developed as a direct result of Roland being left on a commode chair overnight, on a background of changes to Roland's medication regime which reduced his mobility and responsiveness.** **Being left seated for a protracted overnight period, unsupervised and without the required basic care, amounts to neglect.** The medical cause of death was confirmed as: **1a Sepsis** **1b Infected wounds from pressure sore** **2 Frailty, Dementia**
4	**CIRCUMSTANCES OF THE DEATH** Roland Stannard died at the West Suffolk Hospital on the 3rd October 2020. Mr Stannard had been admitted to the West Suffolk Hospital 24 days earlier, on the 9th September 2020 suffering from a serious pressure sore on his sacrum. This pressure sore had developed over the preceding weeks, whilst Mr Stannard was a resident at the Chiltern Meadows Care Home, Stowmarket in Suffolk, having been admitted there on the 25th June 2020. Mr Stannard was taking a drug (Nortriptyline) used to treat a long-term medical condition (vertigo migraines). This condition would make Mr Stannard suffer a number of symptoms including chronic head pain, low blood -pressure, loss of mobility and unresponsiveness. Due to miscommunication and miscoordination between the health care professionals and the staff caring for Mr Stannard, a lower than his usual dose was administered to

	him from the 25th June 2020. Again, due to miscommunication and miscoordination, this lower than usual dose was stopped completely on the 31st July 2020. Mr Stannard 's lower than usual dose, then the removal of Nortriptyline, caused him to develop symptoms that masked his actual physical condition. On the evening and night on the 22nd to 23rd August 2020 Mr Stannard was left sitting on a commode chair overnight. In addition, Mr Stannard 's 4-6 hour incontinence care was not carried out. Mr Stannard was sat on the commode chair for at least 13 hours, but possibly much longer. This triggered the development of a sacral sore. Mr Stannard 's untreated vertigo migraine contributed to Mr Stannard remaining on the commode overnight. Once Mr Stannard 's sacral sore had occurred, due to staff inexperience and lack of training, equipment provided to reduce the further development of the sore, was either not utilised, or if utilised, sometimes used incorrectly. The above factors led to Mr Stannard receiving sub-optimal care, allowing his serious sacral sore to develop.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters given rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you; the **MATTERS OF CONCERN** as follows. – In evidence it was heard that following this incident the Chiltern Meadows Care Home implemented a number of changes to policy, procedures and personnel. However, there is one area of concern which has wider implications which was not addressed. Specifically, once Mr Stannard's sacral sore had occurred, due to staff inexperience and lack of training, the equipment provided to reduce the further development of his sacral sore was either not utilised, or if utilised sometimes used incorrectly. Residential homes, such as the one Mr Stannard was resident in, provide social and personal care, but medical treatment is provided by visiting medical professionals. In Mr Stannard's case his nursing care was provided by visiting District Nursing staff. It was clear that once Mr Stannard had begun to develop a sacral sore, specialist equipment was made available by the District Nurses and provided within short timescales (in one instance the equipment identified as being needed, was delivered and fitted within a 4-hour period). This equipment included a high-grade air alternating mattress and an automatic lateral turning system. However, we were told in evidence that when a District Nurse next visited, the air bed was found to be set too high for someone of Mr Roland's weight (and would therefore not be therapeutic as the bed would be too hard) and that the independent automatic lateral turning system had been unplugged. In relation to the unplugged device, the nurse was told that care staff were unsure of the correct mode of operation for this device so they had contacted the manufacturer

	and were erroneously told it could not be used in Mr Stannard's circumstances. Both issues were identified and rectified when a District Nurse visited Mr Stannard at the home. However, the District Nurses did not necessarily visit every day and due to CoVID19 restrictions in place at the time, also provided online 'virtual' consultations. I am therefore concerned in relation to the provision of specialist equipment to any care home setting, in which the care home staff have insufficient knowledge and training on how to properly operate this specialist equipment. My concern is that in the absence of adequately trained staff, equipment designed to reduce the threat of developing pressure sores (or to aid the treatment of them), will continue to either not be used at all, or if used, used incorrectly. I am further concerned as to what point an assessment should be made to identify whether an individual needs nursing care, rather than continuing social care, and whether the provision of some types of complex medical equipment should prompt such an assessment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th October 2021 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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;- 1. Mr Roland's next of kin. 2. BUPA Chiltern Meadows Care Home, Stowmarket, Suffolk. 3. Dr [redacted] Combs Ford Surgery, Bury St Edmunds, Suffolk. 4. Norfolk and Suffolk Foundation Trust. 5. East Suffolk and North Essex Foundation Trust. I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**17th August 2021** **Nigel Parsley**