




	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Midlands Partnership NHS Foundation Trust (District Nursing team) Beechdene Residential Home Leek Health Centre (GP)</p>
1	<p>CORONER</p> <p>I am Margaret Joy Jones Assistant Coroner for Stoke-on-Trent & North Staffordshire Coroner's Court</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 28/05/2020 I commenced an investigation into the death of Mavis May Lawrence. The investigation concluded at the end of the inquest 30th September 2020. The conclusion of the inquest was:- "The deceased died from natural causes exacerbated by infected pressure sores." The deceased was 87 years of age and suffered with severe dementia. She required full nursing care. She had been resident at Beechdene Residential Home, Leek since September 2018. She had been seen regularly by District Nursing teams to assess and treat her pressure areas but tissue viability nurses were not involved. Preventative measures including pressure relieving equipment were in place; however nursing notes evidenced gaps in pressure care between 3rd December 2018 and the 27th January 2019 when she was admitted to the Royal Stoke University Hospital, Stoke-on-Trent. She was dehydrated and found to have deep ungradable pressure sores and an abscess on her buttock. She was discharged to Goldenhill Nursing Home, Heathside Lane, Stoke on Trent on the 13th February 2019 for end of life care where she died on the 28th February 2019. The cause of death was given as:- 1a. Bronchopneumonia. 1b. Immobility. 1c. Alzheimer's dementia. 2. Old age and infected pressure ulcers.</p>
4	<p>CIRCUMSTANCES OF THE DEATH See above -</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. – The matters that are raised in the safeguarding report:- (1)Nursing notes evidence that pressure areas (sacrum/ buttock/hips) were not checked between 3.12.18 and 11.12.18. Wounds to the sacrum and left hip were documented on the 16.12.18 in nursing notes. (2)No wound treatment assessment charts after the 18.12.18 to document deterioration of pressure areas.</p>

	<p>(3)Nursing notes in December 2018 did not portray a clear story of positioning and changes to the ulcers.</p> <p>(4) The pressure mattress had been turned off on the 22.1.19</p> <p>(5)No record of last visit by district nurses on the 27.1.19</p> <p>(6) There was no evidence that band 4 nurse escalated the seriousness of the situation.</p> <p>(7) There was no evidence that the deceased had been provided with any pain relief and the GP had not been sufficiently involved. .</p> <p>(8) District nurses had not involved Tissue Viability Nurses.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you the Midlands Partnership NHS Foundation Trust; Beechdene Residential Home and Leek Health Centre (GP) have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th November 2020. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely to the family and to the Local Adult Safeguarding Board.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>30/09/2020</p> <p>Signature: </p> <p>Margaret J Jones, HM Assistant Coroner Stoke-on-Trent & North Staffordshire Coroner's Court</p>