IN THE SURREY CORONER'S COURT

IN THE MATTER OF: MICHAEL JOHN HUMPHRIES

The Inquest Touching the Death of Michael John Humphries

A Regulation 28 Report – Action to Prevent Future Deaths

	• **Tadworth Grove Care Home** • **Tissue Viability Nurses, Surrey Down**
1	**CORONER** J Russell-Mitra HM Assistant Coroner, for the County of Surrey
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** An inquest into the death of Michael John Humphries was opened on 30th April 2019 and concluded on 30th April 2021. I found that the cause of death was: I a Sepsis 1b Urinary Tract Infection 1c Renal Calculates and diabetes mellitus 2 Quadriplegia I concluded with Natural Causes as follows: On 20th March 2019 Michael John Humphries, who was quadriplegic and diabetic, was taken by ambulance from his nursing home to Epsom General Hospital. He was found to be suffering from severe sepsis. On 27th March 2019 having not responded to all treatment, he was placed into palliative care and died on 30th March 2019. At post-mortem he was found to have renal calculi, a complication of diabetes mellitus, and this had led to a urine infection which had

	led to sepsis, as a result of which he died. Natural Causes I adjourned consideration of whether to write a report for the prevention of future deaths for further evidence to be provided.
4	i. In 2017 Michael was admitted to Tadworth Grove Care Home. He had been admitted with an indwelling catheter and had a history of urinary tract infections. He was also admitted with a Tbar cushion which had no instructions and none were sought for it. It is believed that it was for neurorehabilitation purposes, but it is not clear how or in what way it was to be used. ii. Michael's catheter was removed sometime in 2018 and he used incontinence pads instead. He was doubly incontinent. After the catheter was removed Michael's recurring UTIs seemed to improve. iii. The home also understood that tissue viability was a complex area and they had undergone some extra training for it, but I have heard that they were not confident about identification or treatment of more complex wounds and that they relied on the Tissue Viability Nurses ("TVN"). The TVN service for Surrey Downs was one full time TVN and one part-time TVN. Referral was via fax. iv. Michael developed pressure sores on his toes and heel which were first noted on 5th January 2019 and was seen by GP and also referred. Those were looked after well and were healing appropriately. However, in order to elevate his leg, the staff incorrectly used the Tbar cushion he had been admitted with – this led to the development of a pressure ulcer on his leg where the cushion had been placed incorrectly. This was first noticed by a nurse who found a dressing had been applied to his leg: no one can identify who applied the dressing to the leg. v. The staff made several referrals to the GP who visited on 18th January 2019 and on 25th January 2019 when she noted redness around the wound and prescribed antibiotics for suspected cellulitis. In fact, the TVN explained that the redness was likely the extent of the pressure damage itself. A referral had been made to the TVN team on 20th January 2019 and they spoke by telephone on 21st January 2019 but did not consider that a visit to Michael was needed. TVN did visit after the home staff remained concerned and sent a second referral. This did lead the TVN to visit on 4th February 2019 and the use of the Tbar cushion was discovered, advice given, and the practice discontinued. Learning investigations were undertaken both internally and by Safeguarding and CQC.

	vi.	Wounds of these kind especially in bedbound diabetic elderly patients are complex in aetiology, development and treatment. The wound was treated first by the nursing staff and then on advice from the TVN.
	vii.	Michael did not show any major signs of deteriorating health this is clear from the nursing notes: on occasion he refused to eat or drink but this was not a consistent pattern. His intake was noted in the notes and charts that had been in place had been discontinued. Michael also did not want to be turned over in bed but was moved regularly for pad changing, personal care, eating, drinking and other necessary activities which was on average about 3 hours.
	viii.	Michael's clinical observations were taken regularly, and his wound checked daily. The wound enlarged and sloughy, did not show signs of infection and his clinical observations were normal.
	ix.	On 20th March 2019 a Care Assistant went to give him breakfast and found him to look significantly unwell. A nurse was called, and observations confirmed that he was very unwell with likely sepsis and after a call to the GP an ambulance was called. There was some hiatus due to difficulty of handover and the expectations of the paramedics that a nurse would attend the hospital.
	x.	Michael was admitted to hospital and immediately treated with broad spectrum antibiotics. He had sepsis from either his leg wound or from a UTI.
	xi.	TVN attended and treated the wound and considered that it was not showing signs of infection and had shown signs of improvement.
	xii.	There was potential for an infection to be present in the bone under the wound and so the wound was investigated for osteomyelitis which was not found to be present.
	xiii.	Full investigation was not continued because Michael did not respond to the antibiotics and was placed into palliative care on 27th March 2019
	xiv.	Michael died on 30th March 2019.
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 could 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. Tbar cushion arrived with Michael without any information on its proper use. 2. I have seen the documentation from the care home where the wound tracking documents are poorly filled in and incorrect information has been recorded. This has made it more difficult to chart the progress of this wound**.** 3. Wound care knowledge was not adequate. 4. Provision of correct dressings not available to non-TVN professionals. 5. Referral system with TVNs was not useful in Michael's case. Initial consultation by telephone was unable to identify issues that would have assisted wound care. 6. Information may be useful to National Wound Care Strategy.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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. 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; Family CQC GP 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	**Signed:** **J. Russell-Mitra** **Dated this 7th March 2022.**