Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: -** **Ms Sue Jacques** **Chief Executive Officer** **County Durham & Darlington NHS Foundation Trust** **Executive Corridor** **Darlington Memorial Hospital** **Hollyhurst Road** **Darlington DL3 6HX**
1	**CORONER** I am Karin Welsh, Assistant Coroner for the City of Sunderland.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 14th May 2015 I commenced an investigation into the death of Margaret Anne Ferry, aged 66. The investigation concluded at the end of the Inquest on 20th October 2015. The conclusion of the Inquest was that Margaret died as a result of the progression of a naturally occurring disease process but opportunities to ameliorate that process were lost as a consequence of a lack of communication. The medical cause of death was: - Ia Bronchopneumonia Ib Necrotising Fasciitis and II Diabetes Mellitus; Raised Body Mass Index
4	**CIRCUMSTANCES OF THE DEATH** Margaret had a number of underlying health issues and was admitted to Sunderland Royal Hospital on 8th January 2015. She underwent a planned amputation of her left 5th toe on 11th January. Thereafter she developed a deterioration to her skin integrity particularly around her abdomen and thighs. On 6th March a referral was made to the plastic surgery team at University Hospital of North Durham. Their role was to provide advice to the treating doctors in Sunderland. There was no clear understanding in each hospital of the role of the other in Margaret's care. There was no clear understanding of the different practices and procedures in each hospital and the impact this would have on Margaret. There was inadequate

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	communication, both written and oral, between the various doctors involved in Margaret's care. Although Margaret was seen by a number of health professionals, including doctors, there was a lack of leadership, meaning that there was no cohesive treatment plan. On 22nd April 2015 Margaret underwent a debridement procedure which, although in itself successful, the missed earlier opportunities meant that Margaret's underlying health problems had been exacerbated and she died on 12th May 2015.
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. Evidence was given at the Inquest that there was no policy in place between City Hospitals Sunderland NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust clarifying the areas of responsibility and channels of communication between the two when patients are referred. 2. Evidence was given that there were poor levels of communication both direct and indirect between medical professionals at each trust and poor understanding of each other's differing practices and procedures.
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 18th December 2015. 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: - • City Hospitals Sunderland NHS Foundation Trust and their Solicitors • Family • CQC 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	Dated this 23rd day of October 2015 Signature _____ Assistant Coroner for the City of Sunderland