REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of Stockport NHS Foundation Trust.
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 22nd November 2016 I commenced an investigation into the death of Marian Dale. The investigation concluded on the 3rd March 2017 and the conclusion was one of died from sepsis, a recognised complication of cellulitis, following trauma to the legs. The medical cause of death was 1a Sepsis;1bCellulitis;1c Trauma to the leg
4	CIRCUMSTANCES OF THE DEATH Marian Dale lived independently at her home address. She injured both her legs in separate accidents. She was treated by the District Nursing Team for one of the injuries. Both legs developed cellulitis and she was admitted to Stepping Hill Hospital. She was treated with antibiotics for the cellulitis. She developed sepsis and died at Stepping Hill Hospital on the 17th November 2016.
5	<u>CORONER'S CONCERNS</u> 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. – Marian Dale had been visited on a regular basis by the District Nursing Team. However, they were unable to give evidence of the condition of her legs and treatment on their visits prior to her death. This was due to the fact that all notes were retained at the patient's address until a full sheet in the hand held

	notes was completed. There was no system for a contemporaneous record to be held centrally. Her notes had not been retrieved after her death and there was no system in place to ensure that happened.
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 16th May 2017. 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 namely [redacted] son of the deceased, who may find it useful or of interest. 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	**Alison Mutch OBE** **HM Senior Coroner** **23rd March 2017**