	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Medical Director, Homerton University Hospital NHS Foundation Trust**
1	**CORONER** I am Heather Williams QC, Assistant Coroner for the coroner area of Inner North London.
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 5 October 2016 an investigation was commenced into the death of Christiana Pelle, aged 83 years old. The investigation concluded at the end of the inquest on 28 March 2017. The inquest found that Mrs Pelle died on 29 September 2016 at Homerton University Hospital, having contracted pneumonia during the period from 9 September 2016 when she was receiving inpatient treatment for an infected pressure ulcer. The conclusion of the inquest was a narrative one (see 4, below) and the medical cause of death was found to be: 1a bronchial pneumonia; 1b sepsis; 1c sacral and calcaneal pressure ulcers.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Pelle was a patient in Homerton University Hospital from 18 May – 22 July 2016, having experienced a fall. The discharge plan envisaged her returning to live at home supported by a care package. She had an earlier diagnosis of late onset schizophrenia. Whilst living at home Mrs Pelle developed a grade 4 pressure ulcer on her sacrum which in turn caused a serious infection that spread to her bones. She was admitted to Homerton University Hospital with this condition on 9 September 2016. The pressure ulcer that became infected was first noted on 10 August 2016 and it then developed during a period when she was under the care of the Community District Nursing team and in receipt of a care package that was planned to involve four visits a day by two carers.
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 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) Lack of clear guidance and thus ongoing uncertainty on the part of the nurses in Homerton's Community District Nursing team as to when they should seek the involvement of a community patient's GP; (2) An ongoing absence of any / any clearly understood system or procedure for sharing relevant information relating to a community patient and/or escalating concerns about the quality of the care they were receiving, between Homerton's Community District Nursing Team and other partner agencies involved - in this instance the Community

	Mental Health Team from the East London NHS Foundation Trust's City and Hackney Mental Health Care for Older People and the London Borough of Hackney's Integrated Independence Team; (3) The lack of a clearly understood system for communicating concerns and/or other relevant information between the Community District Nurses Team and the care provider agency for a community patient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 5 June 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 • The family of Christiana Pelle; • The East London NHS Foundation Trust • Mihomecare Ltd 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	**10 April 2017**