MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
East London Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], CEO, Barking, Havering & Redbridge NHS Trust** [redacted]
1	**CORONER** I am Nadia Persaud area coroner for the coroner area of East 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. 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 26th January 2022 I commenced an investigation into the death of Maureen Edna Dick. The investigation concluded at the end of the inquest on 27th February 2023. The conclusion of the inquest was a narrative conclusion: *Mrs Dick died as a result of a hospital acquired pressure ulcer. Her death was contributed to by neglect.*
4	**CIRCUMSTANCES OF THE DEATH** Mrs Dick was admitted to Queens Hospital on the 4 September 2021. She was very unwell on admission to hospital with likely sepsis from a respiratory source. She had recovered from the respiratory point of view by mid-September 2021. On admission to hospital, she was at very high risk of developing a pressure ulcer, yet she did not receive

	early, careful risk assessment and care planning to prevent the development of a pressure ulcer. Mrs Dick was not re-positioned in accordance with hospital policy and a pressure ulcer developed shortly after her admission to hospital. The sacral pressure ulcer slowly deteriorated over the course of the admission to Queens hospital. By the 24 October 2021 the pressure ulcer had deteriorated to a Grade 3. By the 24 October 2021 the pressure ulcer is likely to have been infected but no medical attention was given to it. There was no wound swab or liaison with microbiology; a lumbar MRI scan was not carried out and no antibiotics were administered. Mrs Dick was transferred to Broomfield Hospital from Queens Hospital with a likely Grade 4 pressure ulcer and osteomyelitis. She received a very good standard of care at Broomfield Hospital, but sadly optimal treatment at this time could not address the severity of her condition. She died on the 8 January 2022 at Broomfield Hospital from her infected hospital acquired pressure ulcer.
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. There was a lack of professional curiosity by the medical staff in relation to investigating the cause of Mrs Dick's severe pain in October 2021. 2. There was a failure by the medical staff to adequately assess the sacral pressure ulcer between the 24th October to 29th October 2021, particularly in light of the increasing white cell count and severe pain complained of by Mrs Dick. 3. There was a failure to diagnose Osteomyelitis at Queens Hospital prior to her transfer to Broomfield Hospital on the 29th October 2021. 4. There is no system for mandatory training for clinical staff in relation to pressure ulcers.
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 **30h April 2023**. 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 of Mrs Dick, Care Quality Commission (CQC). I have also sent it to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**6 March 2023**