H G Mark Bricknell
Senior Coroner
for County of Herefordshire

28th June 2023

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Wye Valley NHS Trust
1	**CORONER** I am Hugh Gregory Mark Bricknell, Senior Coroner for County of Herefordshire
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 9 May 2022 I commenced an investigation into the death of George Edward GRIFFITHS. The investigation concluded at the end of the inquest on 14 June 2023. The conclusion of the inquest was narrative.
4	**CIRCUMSTANCES OF THE DEATH** On 01.2.22, Mr Griffiths went from home by ambulance to A&E, County Hospital, Hereford. He was admitted to the hospital for treatment as it was diagnosed he had an acute kidney injury, gastritis, poorly controlled diabetes and infected toes. Profound metabolic acidosis was noted on a VBG test. He developed worsening hypernatraemia and sepsis. He was also treated for Hyperosmolar Hyperglycaemic State and he was investigated for Fournier's Gangrene. Mr Griffiths was then transferred to ICU for further care and treatment. He had long treatment in ICU and following stepdown back to ward developed delirium. Mr Griffiths developed COVID during his hospital stay and treatment for this was given. He was transferred to a ward for elderly care after his long and complicated admission by which time he had developed a significant pressure sore and C diff diarrhoea. Doctors believe the pressure sore has contributed to death and this occurred during hospital admission.
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) The patient appears to have been held in ED for 40+ hours during which time footwear was not removed. Necrotic Toe apparent without evidence of appropriate management or referral. (2) Skin inspection on admission confirmed that all areas were intact but there is no evidence of preventative care despite patients' time on ED (40 hours) and in AMU (5 days). Acknowledgement of pressure area damage occurred on the 8th February but no reassessment took place until the 20th February with consequent failure to implement pressure relieving measures. (3) The Pressure Sore acquired in Hospital contributed to the death and it is noted that pressure area care training is not mandatory within Wye Valley Trust.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, [redacted] 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 23 August 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 Person: [redacted]. 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	28th June 2023 Signature HG Mark Bricknell, H.M. Senior Coroner