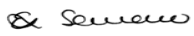
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England; and** **2. University Hospital's of North Midlands.**
1	**CORONER** I am Emma Serrano, Area Coroner, for the coroner area of the Stoke-on-Trent and North Staffordshire.
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 the 1st April 2022, I commenced an investigation into the death of Myra Maxfield. The investigation concluded at the end of the inquest on 15th September 2023. The conclusion of the inquest was a short narrative conclusion of: "Complications following a fall on a background of natural causes" The cause of death was: 1a) Upper gastrointestinal bleed 1b) infected pressure ulcer following hip arthroplasty 1c) Fall II) Frailty of old age
4	**CIRCUMSTANCES OF THE DEATH** i) Myra Maxfield was a 89 year old lady who fell at her home address on the 7 September 2021. During the fall she sustained a fractured right hip. This required surgical intervention and this was carried out on the 9 September 2021. She recovered well from this, and was discharged to the Haywood Hospital, Stoke-on-Trent on the 18 September 2021. ii) During her stay at the Haywood Hospital she developed a pressure sore which developed eventually into a Grade 4 Pressure sore. iii) On the 10 November 2021, she developed symptoms of an upper gastrointestinal bleed, and was taken to the Royal Stoke University Hospital, Stoke-on-Trent where an oesophageal gastro duodenoscopy was performed. She was discharged back to the Haywood Hospital on the 11 November 2021. iv) This hospital continued to treat the pressure ulcer, which developed until the 3 December 2021 when she was admitted to the Royal Stoke University Hospital, the pressure ulcer had progressed and she had osteomyelitis. She was treated until being discharged to the Haywood Hospital on the 23

	December 2021. v) She was treated there, and her pressure ulcer began to hea,l however, she deteriorated rapidly on the 11 March 2022 with a further upper gastrointestinal bleed. She was admitted to the Royal Stoke University Hospital, where she passed away on the 12 March 2022 as a result of the bleed, the fall and the pressure ulcers.
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 emerged during the inquest that it was crucial that patients who were at risk of developing pressure ulcers, had ulcers already, or had developed them whilst in hospital, saw the Tissue Viability Team as soon as possible, and usually within 6 hours. 2. It was said that, delays in doing so, could be causative in the death of patients. 3. Evidence emerged that at the Royal Stoke University Hospital, Tissue Viability is not available over the weekend, and this leads to substantial delay in patients being seen.
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 15 December 2023. 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 Myra Maxfield. 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	**25 October 2023**  **Miss Emma Serrano**

	Area Coroner **Stoke-on-Trent and North Staffordshire's Coroners Area**