REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health and Social Care**
1	**CORONER** I am Lauren Costello, Assistant Coroner, for the Coroner Area of Manchester South
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 24th May 2023 an investigation was commenced into the death of Elizabeth Roberts then aged 91 years. The investigation concluded at the end of the inquest on 19th December 2023. I recorded a narrative conclusion that Mrs Roberts died from sepsis with congestive cardiac failure due to underlying ischemic and valvular heart disease with the superimposed physiological burden of sacral ulceration on a background of severe frailty. The medical cause of death being: 1a. Sepsis with congestive cardiac failure 1b. Ischaemic & hypertensive heart disease with superimposed sacral ulceration on background of severe frailty

4	**CIRCUMSTANCES OF THE DEATH** Mrs Roberts was severely frail and bedbound with urinary and faecal incontinence. She had ischaemic and hypertensive heart disease and developed a large sacral sore with associated sepsis. These conditions precipitated congestive cardiac failure. She was admitted to Tameside General Hospital on 19th May 2023 where despite treatment, she died the same day of Sepsis with congestive cardiac failure. The inquest heard that Mrs Roberts was supported by care agency carers four times per day and the District Nursing Team. Following a Tissue Viability assessment on 20th April 2023 the frequency of visits by the District Nursing team was increased to daily until Mrs Roberts was admitted to Tameside General Hospital on 19th May 2023. The Inquest heard that the care agency raised concerns with Adult Social Care because her dressings were not being changed daily. In addition, Mrs Robert's family raised concerns as did the hospital nurse responsible for Mrs Robert's care on 19th May 2023. As a result, an investigation was opened by the District Nursing Service. The Inquest heard that insufficient dressing changes for a sacral sore can lead to localised and systemic infection due to the risk of a sore in that area of the body being contaminated with urine and faeces. The family were told on several occasions that the nursing team did not have time to change dressings. On 17th May 2023 a nurse did not attend to care for Mrs Roberts due to demands upon the District Nursing Team. The team offered instead an out of hours visit that would have disturbed Mrs Roberts and her family from sleep and so this was not accepted. The Inquest heard that there are ongoing staffing issues within the District Nursing Team. Following the Serious Incident Investigation, a number of measures have been undertaken by the Tameside and Glossop Integrated Care NHS Foundation Trust to address issues identified with the care of Mrs Roberts and with the district nursing service generally including: • Introduction of weekly compliance checks for Waterlow, MUST and body mapping policies. • All District Nursing Visits deferred to the out of hours service must be approved by Sister of Team leader. However, the Inquest heard that despite a number of steps taken locally to manage the District Nursing Service such as using a variety of different staffing grades for visits, staffing shortages cannot be rectified by local action without a change of approach nationally.
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) Despite a number of measures being undertaken by Tameside and Glossop Integrated Care and NHS Foundation Trust, the Inquest heard that there are residual staffing shortages in the District Nursing Service which the Trust is unable to resolve without a change of approach nationally.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 29th February 2024. 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: [redacted] [redacted], legal representative for the Trust 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. 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	**Lauren Costello** **HM Assistant Coroner** L. Costello **4th January 2024**