REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Care Quality Commission, Chief Executive of the One Stockport Integrated Care Board
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater 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 10th February 2023 I commenced an investigation into the death of Susan Wendy BRACEGIRDLE. The investigation concluded on the 3rd July 2023 and the conclusion was one of Narrative: Died from osteomyelitis where the deterioration of the sacral pressure ulcer was not recognised until she became very unwell and attempts to treat it were unsuccessful. The medical cause of death was: 1a Osteomyelitis secondary to infected sacral pressure sore; II Vascular Dementia
4	CIRCUMSTANCES OF THE DEATH Susan Wendy Bracegirdle had limited mobility and was at high risk of developing pressure ulcers. She resided in a care home. The District Nursing team were responsible for management of the pressure ulcer that she developed. In October 2022 the pressure ulcer became a stage 3 pressure ulcer. The District Nursing team continued to manage it with support from the Tissue Viability team. On 9th December the wound showed signs of exudate and smelt. On 11th December 2022, Mrs Bracegirdle was hot to the touch when seen by the district nurses. A remote GP review prescribed a cream. No observations were taken. On 13th December 2022 care staff escalated Susan Bracegirdle to the GP. She was referred to the community intravenous team for antibiotics and on 14th December to a nursing bed in the home. On 16th December 2022 Mrs Bracegirdle was taken to Stepping Hill Hospital as she was deteriorating further. On admission she was very unwell. She was treated for sepsis. She became frailer and her physiological reserves were significantly reduced. A MRI scan confirmed Osteomyelitis. Despite continuing treatment with antibiotics Mrs Bracegirdle continued to

	deteriorate and died at Stepping Hill Hospital on 9th February 2023.
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 inquest heard evidence that because Mrs Bracegirdle was in a care home setting the District Nurses were responsible for management of her pressure ulcers. The care home was asked to ensure pressure relieving processes were followed. However, the District Nurses did not share care plans with the care team on the basis that they were digital documents and were care plans for the use of District Nurses. As a consequence, the care home management were not fully sighted, and joint care was more difficult to deliver increasing the risk of the pressure ulcers deteriorating. 2. There was no communication strategy in place as a consequence of an approach that did not promote team /joint working. The inquest heard that as a consequence the family were unsighted on the condition of Mrs Bracegirdle until shortly before her admission to hospital. This meant that the family could not support the work to reduce the risk of the pressure ulcers deteriorating further and were not able to be a proactive about the care she was receiving increasing the risk of her pressure ulcers deteriorating 3. The GP was asked to provide input. Due to a lack of information sharing the GP who dealt with Mrs Bracegirdle does not seem to have appreciated the extent of the issue and as a consequence there was no face-to-face examination and antibiotics were not started. 4. There had been a safeguarding review undertaken. However key people involved in her care had not provided input to the review which meant there was no clear holistic assessment of what lessons could be learnt to reduce the risk of deaths from pressure ulcers in the future. It was unclear why such an approach had been taken 5. An earlier internal review by the District Nursing team when Mrs Bracegirdle's pressure ulcer became a category 3 was not shared or discussed with the family and they were unsighted on the issue.

	6. The Tissue Viability team had been asked by the District Nurses for input. This was provided remotely via access to photos taken by the District Nursing Team. Whilst it was clear that remote review could be effective it was not in this case because the review was based on an older image and an updated image showing a deteriorating picture in relation to the pressure ulcers was not uploaded. This was as a result of lack of joint working and effective communication. The impact was that what would have been helpful expert input from the TVN was not provided to a deteriorating picture.
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 29th March 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 namely [redacted], on behalf of Ms Bracegirdle's family, and Stable Steps Care Centre, who may find it useful or of interest. 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	Alison Mutch HM Senior Coroner  02.02.2024