	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of County Durham and Darlington NHS Foundation Trust**
1	**CORONER** I am Janine Richards, assistant coroner, for the coroner area of Durham and Darlington.
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 16th of September 2022 an investigation into the death of Stanley Cummins, aged 84, was commenced . The investigation concluded at the end of the inquest on 1st of March 2024. The conclusion of the inquest was a narrative conclusion as follows:- Stanley Cummins, who was 84 years old, died at his home address on the 2nd of September 2022. His death was caused by a pressure ulcer to his heel which became necrotic and led to sepsis. The pressure ulcer was caused as a result of the deceased sitting for long periods of time in a chair and pushing his heel onto the floor in an attempt to reposition, as he was in discomfort from damage which he had also sustained to his bottom. The pressure damage occurred in his care home between the 18th of July and the 2nd of August 2022, where he had been admitted for rehabilitation. The ulcer was an avoidable injury with appropriate care and management of the known high risk of pressure damage. Despite pressure damage being noted to the deceased including to his buttocks and legs there were no comprehensive changes to his care regime, to reduce the risks of further damage occurring, or to manage the pressure damage that had already been caused, becoming worse. There was no referral to the District Nursing team or other professionals for further advice in relation to pressure damage. If the skin had been appropriately monitored it is likely that the early effects of pressure damage to the heel would have also been identified, at which point pressure relief and offloading should have been provided. Once the deceased returned home and the pressure damage to the left heel was identified, no offloading advice or recommendations were given to family and carers from the nursing team responsible for his care, and it is likely that despite the deceased's other risk factors for pressure damage and for delayed healing of such, that with appropriate advice and care, namely complete offloading, amongst other measures, that further deterioration and evolution of the wound, would have been avoided. The deceased died of sepsis, the underlying cause of this was the pressure sore to the left heel which developed into a necrotic ulcer. The wound was preventable with appropriate care and further deterioration of the wound was also preventable. The death was contributed to by neglect.

4	**CIRCUMSTANCES OF THE DEATH** Stanley Cummins, who was 84 years old, died at his home address on the 2nd of September 2022 where he had been discharged on a palliative basis. His death was caused by a pressure ulcer to his heel which became necrotic and led to sepsis.
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. During the Inquest I heard evidence from the Matron for Clinical Governance and Quality, responsible for the community nursing team responsible for Mr Cummins care, in relation to the work being undertaken to improve community nursing teams ability to comprehensively identify, record, treat and escalate, as necessary, pressure wounds. I was not provided with comprehensive evidence that lessons had been learnt in relation to the accepted failings in this case, and in particular the failure by the District Nursing team to provide appropriate offloading advice and recommendations to family and carer's in accordance with NICE guidelines, once pressure damage to the heel had been identified, or to escalate these issues as needed to other services and professionals. The majority of the further training and protocols that the matron considered were appropriate to try to improve patient safety in relation to pressure wounds, were described to me as being a work in progress with no certainty as to when these would be completed.
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 29.04.24. 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 - the family of Stanley Cummins, and to the care home in which he resided for a time. 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	**04.04.2024** **SIGNED BY CORONER**