ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. St Andrew's Surgery Hull** **2. Hull University Teaching Hospital** **3. NHS England** **4. Care Quality Commission** **5. Nursing and Midwifery Council** **6. City Healthcare Partnership Hull**
1	**CORONER** I am Sally Robinson, Assistant Coroner, for the coroner area of East Riding of Yorkshire and City of Kingston Upon Hull.
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 17th February 2023, an inquest was opened and adjourned into the death of Linda Heath aged 76 years. The investigation concluded at the end of the inquest on 12th April 2024, the conclusion of the inquest was a narrative conclusion. Box 3 referred to box 4 of the Record of Inquest which read: Linda Heath died on 31st March 2022 at Hull Royal Infirmary from sepsis which was caused by an infected sacral sore. She had been discharged in February 2022 with a grade 2/healing sore and a concatenation of management issues by healthcare professionals including her not being referred for district nursing care led to a worsening of her condition which, alongside her pre-existing comorbidities, ultimately led to an admission to Hull Royal Infirmary on 5th March 2022. Despite surgical treatment the situation worsened, and tissue viability nursing was not reinstituted post operatively. Ultimately, following difficulties in care with nutrition and hospital acquired infections, Mrs Heath succumbed to sepsis and died on 31st March 2022 following cessation of active treatment. Her medical cause of death was recorded as: **1a** Sepsis **1b** Infected sacral sore **1c** Poor mobility **II** Pneumonia, multi–level degenerative discopathy, central canal stenosis, atrial fibrillation, chronic kidney disease, hypertension, obesity

4	**CIRCUMSTANCES OF THE DEATH** Mrs Heath was discharged from hospital on 11th February 2022 with a sacral sore. The Immediate Discharge Summary (IDS) did not mention that a district nurse referral was required nor was a referral made by the hospital. Mrs Heath had a private domiciliary care package in place, but little enquiry was made of the remit of those carers by the hospital. The nursing summary on 10th February stated that the care would be transferred to the district nursing team to include dressing selection and equipment required at home. This did not get added to the IDS. Mrs Heath lived independently and had the support of her family and the domiciliary carers. She did not have district nursing care. Mrs Heath telephoned her GP on 14th February 2022 regarding the pressure sore and was prescribed Zenoderm cream. This was not a face-to-face appointment. The doctor advised that a photograph be sent of the sore. Carers took a photograph at Mrs Heath's request, and it was sent to the GP. No referral to the district nursing service was made. On 17th February Mrs Heath failed to attend a routine bloods appointment as she was in too much pain from the pressure sore. A district nursing referral was not made either to take the blood samples or to assess the pressure sore. On 3rd March Mrs Heath once again telephoned the GP and told them her condition had worsened. This prompted the GP surgery to arrange a home visit which took place on 4th March. Mrs Heath was transferred to hospital following that visit as the sore had become unmanageable in the community. Despite surgical treatment and care in Hull Royal Infirmary Mrs Heath sadly died on 31st March 2022.
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 Immediate Discharge Summary did not include relevant or sufficient information about treatment in the community needs or a nursing summary. (2) Despite the presence of a difficult sacral sore which would have benefitted from district nursing care, no referral was made post discharge by the GP surgery. (3) No trigger appears to exist whereby GPs conduct follow up enquiries or visits to patients who have recently been discharged from hospital and who are complaining of a condition which may worsen and failing to attend routine appointments due to a worsening of their condition. (4) An over reliance upon private hygiene care packages with insufficient inquiry into the parameters of care provided by the private domiciliary carers.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 4th June 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: the family of Linda Heath and their representatives, Hull University Teaching Hospitals and Community Health Care Partnership as well as the agencies identified at the top of this report. 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	**[DATE]** **[SIGNED BY CORONER]** ***9th March 2024*** ***Sally Robinson, Assistant Coroner***