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. Safeguarding Adults Team, East Riding of Yorkshire Council**
1	**CORONER** I am Miss Sarah Middleton, Assistant Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
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 18th October 2023 I commenced an investigation into the death of Janet Brown Townend, aged 80 years. The investigation concluded at the end of the inquest on 25th October 2024. The narrative conclusion of the inquest was: On 15th October 2023, Janet Brown Townend aged 80 years died at HRI from sepsis which she developed from an infected wound on her foot. She was diabetic and she sustained an injury to her foot on 19th September 2024 and this developed into a further wound under her foot due to poor circulation that became necrotic and infected. She was admitted to hospital on 7th October 2024. Despite surgical treatment her infection worsened and she succumbed to sepsis. Her comorbidities contributed to her lack of ability to deal with the infection.
4	**CIRCUMSTANCES OF THE DEATH** Janet Brown Townend had a number of comorbidities. Following a heart attack in August 2023 she was in receipt of a care package, sourced by East Riding of Yorkshire Council, and provided by A&B Healthcare Ltd. Ms Townend sustained an injury to her toe on 19th September 2023. Her carers contacted the podiatry team. She was seen by a Band 7 specialist in diabetic foot service on 26th September 2024. There were concerns regarding her reduced circulation and peripheral neuropathy and she was referred to see the vascular team. An appointment was made for 5th October 2023. It was thought there was a fracture to her toe with an open wound. Ms Townend was prescribed antibiotics and was to be seen by community nurses twice a week to apply dressings. Carers continued to attend 3 times a day to assist with meal preparation and personal care. The Yorkshire Ambulance Service Patient Transport Service was booked by Ms

	Townend to take her to her vascular appointment on 5th October 2024. Unfortunately, when they attended to take her, they were unable to do so as one crew member was not able to mobilise Ms Townend safely to the vehicle due to her limited mobility. As a result, Ms Townend cancelled the appointment, and a further appointment was rebooked for 12th October 2024. On 6th October 2023 carers observed Ms Townend struggling to sit up. A Health Care Assistant (HCA) from the Community Nurses' Team attended and was concerned as to Ms Townend's foot and the level of exudate. Her toe was black underneath. The HCA sent photographs to a senior nurse who determined Ms Townend should be seen the following day by a registered nurse. The next day, 7th October 2023, the registered nurse attended at the same time as a carer in the morning. Ms Townend presented as vacant and confused. An ambulance was called. Her leg was warm and swollen. A black necrotic area was noted to her foot. Ms Townend's daughters also attended at this time. Her daughter described a smell of dead flesh and her mother being delirious and slumped in a chair and having been in the same clothes for 2 days. The ambulance took her to hospital. She had a cardiac arrest on the way but was resuscitated. As a result of what the ambulance practitioner witnessed, she submitted a Safeguarding Adult Concern to East Riding of Yorkshire Council regarding neglect and acts of omission due to the care she had received and the injury to her foot On admission to Hull Royal Infirmary, she had an infection to her left foot and sepsis. Bacteria was found on her foot which caused an infection leading to sepsis. She was given antibiotics and the next day had a debridement and amputation of 2 toes. Although initially there was clinical improvement in Ms Townend's condition she deteriorated and despite treatment died on 15th October 2023. The medical cause of death was determined as: 1a Sepsis 1b Infected wound of the left foot (operated 8/10/2023) 2 Ischemic heart disease; Diabetes mellitus; Chronic kidney disease.
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. There was a referral to Adults Safeguarding from both Yorkshire Ambulance Service and Hull Royal Infirmary regarding concerns as to the care Ms Townend had received. As a result of the referrals there was a review that was deemed necessary. However, the quality of that review was lacking. The Safeguarding Adult Review that took place did not probe the responses received appropriately from the care company and the Community Nurses in any way. In evidence it was heard that the procedure adopted did not record how the responses had been obtained. The family's input was not recorded. The process happened hastily and the review not to the appropriate standards that would have been of any benefit. The outcomes of the review and recommendations were not provided to the subjects of the review.

	In evidence it was heard that there was a lack of professional curiosity and the full review process not followed or documented properly. The importance of Safeguarding reviews must not be underestimated. They are in place to identify concerns and prevent any such issues occurring in the future. The procedure conducted needs to be looked at to avoid any impact on anyone else.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action by ensuring thorough safeguarding reviews take place and all parties are notified of the conclusion and involved fully in the process.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30th December 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 Janet Brown Townend. 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	**4th November 2024**