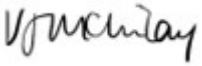
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Vanessa McKinlay, Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 13 June 2024 I commenced an investigation into the death of Phyllis TROMANS. The investigation concluded at the end of the inquest . The conclusion of the inquest was: Mrs Tromans died as a result of an infected pressure ulcer to her right hip which developed when she was an inpatient in Queen Elizabeth Hospital, to which gaps in her pressure area care during that admission made a contribution.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Tromans was a long term resident at Cotteridge House Residential Home. She had Parkinson's disease and was in a frail condition. On 17 March 2024 she was admitted to Queen Elizabeth Hospital where she was treated for pneumonia but where her condition did not improve and she was assessed as being for end of life care. Whilst in hospital, she developed a grade 4 pressure ulcer of her right hip, to which gaps in her pressure area care made a contribution. She died at Cotteridge House on 24 May 2024. Following a post mortem performed by [redacted], the medical cause of death was determined to be: 1a Infected Pressure Related Ulcer Right Hip 1b 1c 1d II Frailty, End stage Parkinsonism with immobility
5	**<u>CORONER'S CONCERNS</u>** 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. It is likely that Mrs Tromans' tissue damage started during her period in the Emergency Department. On admission, her Waterlow score indicated a high risk of pressure sores. That score was underestimated and the correct score would have indicated a very high risk. She spent almost 18 hours in ED, during which time she was positioned on a trolley

	without pressure area care. 2. Mrs Tromans had a repositioning schedule in place when she was admitted to the Acute Medical Unit and subsequently to ward East Ground B. This required repositioning at no greater intervals of four hours to mitigate the risk of pressure sores. On a total of 22 occasions the schedule was not adhered to. This led to occasions where Mrs Tromans was left in the same position for up to 14 hours. 3. East Ground B ward had a paper version of a wound care plan which was designed to provide detailed monitoring of her skin condition and a treatment plan for pressure sore care. This was not completed at any stage. 4. The Matron's investigation into these gaps in care did not seek to establish why they had occurred. This raises a concern about the quality and efficacy of the Trust's post-death investigations which in turn raises a concern for future deaths.
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 27 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: [redacted] (Mrs Tromans' daughter) I have also sent it to the Medical Examiner, ICS, NHS England and CQC. 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	**1 November 2024** Signature:  **Vanessa McKinlay** **Assistant Coroner for Birmingham and Solihull**