OFFICE OF THE
SENIOR CORONER
for the County of West Yorkshire
(Eastern District)

His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield WF1 2TS

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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Meanwood Group Practice**
1	**CORONER** I am Emma Mather, Assistant Coroner, for the Coroner area of West Yorkshire (East).
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 29 July 2022 an investigation was commenced into the death of Karen Lesley Day, aged 58. The investigation concluded at the end of the Inquest on 28 November 2024. The medical cause of death was 1a) Septicaemia 1b) Soft tissue infection, Pneumonia 1c) Traumatic Laceration II) Raynaud's disease. The conclusion of the Inquest was: Accident.
4	**CIRCUMSTANCES OF THE DEATH** Karen Lesley Day sustained a small laceration to her left lower leg in 2021 when she injured it on a van. She sought help from her GP practice to manage the wound in June 2021 and appointments with the practice nursing team commenced. Over the course of the following 11 months, Karen attended multiple appointments where the appropriate lower limb framework was not followed and opportunities to escalate Karen's deteriorating wound and overall condition were missed. Karen was admitted to hospital on the 26th May 2021 and was treated for an acute infection following which she was discharged to the care of the district nursing team. The lower limb framework was not used consistently and opportunities her increasing deterioration was not fully recognised and escalated. She was admitted to hospital on the 12th July 2022 where she was, by this point, extremely unwell. The hospital commenced active treatment to which she did not respond and care was orientated towards palliation and comfort. Karen died on the 14th July 2022.

5	**CORONER'S CONCERNS** During the course of my investigation my inquiries 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: (1) During the course of the inquest I heard evidence that the GP practice did not follow the lower limb framework, failed to refer to tissue viability appropriately, and failed to escalate concerns around the deteriorating wound or consider appropriate measures to support the deceased to either self-manage her wound with an at home compression bandaging kit, or to support her to attend appointments on a more regular basis. I am concerned that the practice was unable to provide assurance that the same situation could not occur again. (2) During the inquest I received evidence that the practice had not carried out any internal investigation in relation to this death and the practice accepted it should have done. I am concerned that the practice does not have adequate systems in place to ensure that patient safety incidents are reviewed in a timely way to allow lessons to be drawn from the findings.
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 Friday 07 February 2025. 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 1. the Leeds Teaching Hospital NHS Trust and 2. the Leeds Community Healthcare NHS Trust and to 3. the family who may find it useful or of interest. I am also copying my report to the Care Quality Commission (CQC) and the Integrated Care Board (ICB). I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me at the time of your response, about the release or the publication of your response by the Chief Coroner.

9	**Signed**:  **EMMA MATHER** **Assistant Coroner** **West Yorkshire (E**)	**Date:** 10 December 2024