ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], CEO Lewisham and Greenwich NHS Trust, University Hospital Lewisham, Lewisham High Street, Lewisham, London SE13 6LH** **2. [redacted], Chief Executive, London Borough of Lewisham, Laurence House, 1 Catford Road, London, SE6 4RU**
1	**CORONER** **I am Liliane Field for London Inner South**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 14 February 2023 I commenced an investigation into the death of Naomi SULEYMAN. Ms Suleyman died on 9 February 2023 at University Hospital Lewisham, London (UHL) part of Lewisham and Greenwich Trust (LGT) where she had been admitted from her home on 3 January 2023 with complications of an unstageable pressure ulcer. The investigation concluded on 17 January 2025. I recorded a narrative conclusion: Naomi Suleyman died from pneumonia and complications of an unstageable sacral pressure sore which she developed having deconditioned and become bedbound following discharge from hospital whilst undergoing assessment of her long-term needs.
4	**CIRCUMSTANCES OF THE DEATH** Ms Suleyman was admitted to UHL on 06.11.22 with pneumonia. She was noted to have a grade 2 sacral pressure ulcer on admission and subsequently developed a sacral deep tissue injury (DTI) requiring the input of the tissue viability nurses (TVN). The DTI appeared to resolve, resulting in her discharge from the TVN caseload, albeit the grade 2 sacral pressure ulcer remained. She was discharged home on 05.12.22 with a package of care arranged through LGT's and London Borough of Lewisham's (LBL) integrated multi-disciplinary discharge to assess (D2A) service for assessment of her long-term needs and with a referral to LGT's District Nursing Service. By 07.12.22 she had developed a new DTI. The DTI progressed to an unstageable pressure sore and she was re-admitted to UHL on 03.01.23 with sepsis from pneumonia and from the sacral pressure sore which had become infected and had progressed to osteomyelitis.

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. – In respect of the D2A service (LGT and LBL): (1) The 'discharge passport' completed by the UHL in-patient team was inaccurate, failing to record Ms Suleyman's vulnerability to pressure ulcers, the need for therapies input from day 1, the equipment she required and that her home environment had not been optimised to meet her needs both in terms of equipment and layout. Whilst I heard that scrutiny of the discharge passport had improved at ward level, deficient discharge passports were still filtering through to the D2A team. (2) The deficiencies in the discharge passport were not identified when it was screened by the LGT Hospital Flow Centre. (3) On the day of discharge, Ms Suleyman should have received a welfare check from the LBL out of hours social worker which did not happen. (4) Due to lack of capacity, Ms Suleyman's interim care needs pending assessment were brokered to a care provider. As a result, she did not receive a visit from a social worker and/or occupational therapist within 24 hours of discharge as she would have done if her care needs had been provided by the in-house Enablement team. In respect of the involvement of the District Nursing Service (LGT) (1) The referral to the District Nursing team was incorrect in that it wrongly referred to Mrs Suleyman having a sacral DTI on discharge. This led the District Nursing team to believe that she was already on the caseload of the community TVN team. This resulted in a delay in her being assessed by them. (2) There was little communication between the therapists from the D2A team and the District Nurses. As a consequence of these deficiencies there were missed opportunities to recognise that Ms Suleyman's discharge was unsafe and act upon that. The issues relating to LBL only emerged in evidence during the inquest. LGT in-patient and District Nursing services have taken some steps towards addressing their deficiencies. However, there has been a fragmented and incomplete response. There has been no overarching coordinated investigation involving all the key services relevant to what is intended to be an integrated multi-disciplinary discharge process.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Lewisham and Greenwich NHS Trust and London Borough of Lambeth 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 26 March 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 (1) Mrs Suleyman's family (2) Lewisham and Greenwich NHS Trust and to London Borough of Lambeth (who were not Interested Persons) 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]**  **29th January 2025** **Liliane Field Assistant Coroner for London Inner South**