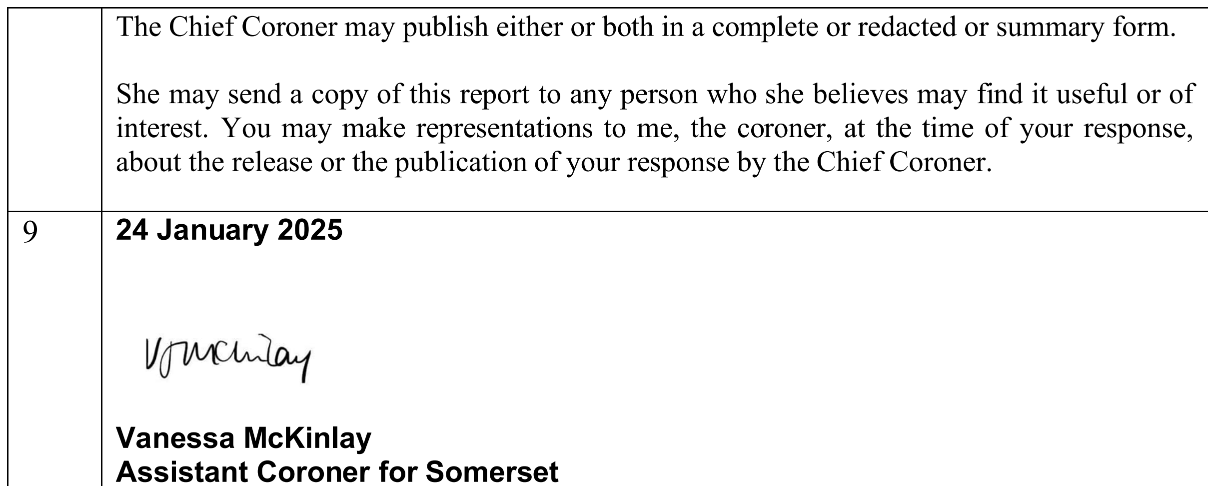
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Somerset NHS Foundation Trust**
1	**CORONER** I am Vanessa McKinlay, Assistant Coroner for Somerset
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 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 27 December 2023 I commenced an investigation into the death of Cynthia Mary Gilbert. The investigation concluded at the end of the inquest on 23 January 2025. The conclusion of the inquest was that Mrs Gilbert died as a result of natural causes contributed to by gaps in the implementation of the pressure ulcer care plan in hospital.
4	**CIRCUMSTANCES OF THE DEATH** Against a background of cardiac and respiratory illness, Mrs Gilbert's mobility had deteriorated at home. She was found on the morning of 30 August 2023 on the toilet, where she had been all night having been unable to stand herself up. She was admitted to Musgrove Park Hospital where she was discovered to have an infective exacerbation of her chronic obstructive pulmonary diease and grade 2 tissue injuries to the sacrum and buttocks. During a long hospital admission, Mrs Gilbert's pressure ulcers deteriorated and became infected, owing in part to her multiple co-morbidities and in part to gaps in the implementation of her repositioning care plan. This caused septicaemia from which Mrs Gilbert died in hospital on 20 December 2023. The medical cause of death was determined by [redacted] (Mrs Gilbert's treating Consultant Physician) to be: 1a Septicaemia 1b Pressure ulceration 1c Immobility 2 Chronic obstructive pulmonary disease, Congestive cardiac failure, Atrial fibrillation

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: a) Mrs Gilbert was noted to have grade 2 tissue damage on admission to hospital. She was assessed as being at very high risk of pressure ulcer development. Her care plan included repositioning every 1 to 2 hours. The Intentional Rounding documents show that, during her time spent on the Old Acute Medical Unit and Coleridge Respiratory Unit (1/9/23 to 20/12/23), Mrs Gilbert remained in the same position in bed for periods of many hours on multiple days. b) Evidence given by the tissue viability nurse was that the tissue viability team emphasised the importance of repositioning on five separate occasions to the ward staff. The lack of adherence to the repositioning plan continued despite these communications. c) Mrs Gilbert’s grade 2 tissue damage deteriorated to a grade 4 pressure ulcer during her admission, leading to septicaemia. d) The lack of adherence to the repositioning care plan for a patient at very high risk of developing pressure ulcers raises a concern for future deaths. e) The evidence given by the Trust at the inquest did not provide a satisfactory explanation as to why the repositioning care plan was not adhered to. This raises a concern about the quality and efficacy of the Trusts’ post-death investigation 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 21 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: [redacted] (Mrs Gilbert’s 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. 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, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**24 January 2025** **Vanessa McKinlay** **Assistant Coroner for Somerset**