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. The Chief Executive(s) of Herefordshire and Worcestershire Health and Care NHS Trust and Worcestershire Acute Hospitals Trust**
1	**CORONER** I am James Puzey, assistant coroner, for the coroner area of Worcestershire
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 10 January 2024 HMSC David Reid commenced an investigation into the death of Katrina Veronica Francesca Insleay, aged 90. The investigation concluded at the end of the inquest on 12 December 2024 which I heard. The conclusion of the inquest was that the medical cause of death was Sepsis due to an infected sacral pressure sore and pneumonia.
4	**CIRCUMSTANCES OF THE DEATH** 1. Katrina Insleay died on 1 January 2024 at the Alexandra Hospital, Redditch from sepsis due to an infected pressure sore and pneumonia. Ms. Insleay went into hospital on 18 November 2023 with what was a low-grade pressure sore. She remained under the care of hospital clinicians or community health professions from that point until she died on 1 January 2024 and during that time the condition of her pressure sore became worse and she developed sepsis therefrom. 2. Evidence was given at the inquest by a Clinical lead with the Pershore and Upton Neighbourhood team that Ms Insleay was discharged home from Worcestershire Royal Hospital on 4 December 2023 and that the Pershore and Upton Neighbourhood Team received a telephone call from the patient discharge unit at the hospital that day. Information received was that Miss Insleay had a grade 2 pressure to her sacrum which had developed in hospital. The Neighbourhood team were asked to visit the patient on Thursday 07/12/2024 to redress the sacral pressure ulcer and check the hip wound. They were advised that the sacral pressure sore should be redressed twice weekly. A visit was planned for the 07/12/2024. 3. In fact, the pressure sore was at least a grade 3. I was told that pressure sore assessment is, to a degree a subjective exercise of judgment but the evidence in this case was that the grading of the sore by the hospital as a grade 2 was clearly wrong. 4. As it happens the Neighbourhood Team visited on 5 December 2023 because it was reported to them that the dressing had come away

	from the wound. However, owing to miscommunication the results of the swaps taken of the pressure sore were not acted upon promptly and the pressure sore developed an infection which became worse and sepsis was the result. 5. The evidence from the clinical lead was that the Neighbourhood Team ("NT") and the Hospital had completely different record keeping systems and the NT could not simply check the hospital records without specifically requesting them. The handover between hospital and NT for patients being discharged from hospital was often by telephone and only sometimes was there a handwritten form. There was no formal, documented handover procedure that was capable of being checked. The NT did not always receive the discharge letter. The images of Ms Insleay's wound that were taken at the hospital were not available for the NT to view unless they specifically requested them. Consequently, absent the dressing becoming loose, there would have been no visit between 4 and 7 December 2023 and the actual state of the pressure sore would not have been observed until even later.
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. – (1) The absence of a formal, documented handover system between hospital and Neighbourhood Team and the fact that the NT cannot simply check hospital records of patients with pressure sores to verify their condition without specifically requesting records creates the potential for the NT to fail to appreciate the true condition of a patient's pressure sores when they are discharged from hospital and for follow up to be delayed. This increases the risk of wound infection and consequent sepsis. (2) I am informed (letter received from HWHCT on 31.1.25) that there are established handover procedures and that a statement of practice is being drafted to "formalise" the referral requirements between hospital and NT. I am informed also that an App is being developed which can be used to record and check the condition of pressure sores and that it has the potential to be used across acute and community services. I do not consider that these proposals are sufficiently detailed, precise and concluded to address the concerns that I have expressed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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. 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 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	**6 February 2025** **HMAC James Puzey**