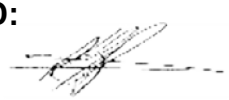
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 28 NOVEMBER 2024 IS BEING SENT TO:** **Chief Executive – Royal Devon University Healthcare Foundation Trust.** **Family of Mr Raymond Albert Alfred Reid.** **Chief Coroner.**
1	**CORONER** I am Philip SPINNEY, HM Senior Coroner, for the coroner area of The County of Devon, Plymouth and Torbay.
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 9 March 2023 an investigation was commenced into the death of Raymond Albert Alfred Reid. The investigation concluded at the end of the inquest held on 27 November 2024. The conclusion of the inquest was as follows: *Raymond Albert Alfred Reid died due to sepsis caused by recurrent urinary tract infection, pressure sores and pneumonia on a background of severe frailty.*
4	**CIRCUMSTANCES OF THE DEATH** On 6 January 2023 Raymond Albert Alfred Reid was admitted to North Devon District Hospital with a catheter related urinary tract infection. During a prolonged hospital stay Mr Reid did not respond to treatment and developed further complications of pressure sores and pneumonia. Despite treatment Mr Ried continued to deteriorate and sadly died in North Devon District Hospital on 1 March 2023.
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) Mr Reid died as a consequence of sepsis caused by a combination of a urinary tract infection (UTI), pressure sores and pneumonia; it was established during the evidence that it would not be possible to determine to what extent the infection resulting from the UTI, the pressure sores and the pneumonia individually contributed to the cause of death. (2) The pressure sores developed in hospital and the deterioration of the pressure sores was possibly caused by gaps in care and knowledge. More particularly the evidence at the inquest (and the findings of an internal concise investigation) revealed that: a. A first skin check was not completed within 6 hours of admission in accordance with Trust policy. b. The pressure ulcer risk assessment was not completed within 6 hours of admission and was not repeated daily in accordance with Trust policy. c. Skin checks were not routinely documented – there were 21 intermittent days when a skin check was not recorded. d. A malnutrition universal screening tool assessment was not completed in accordance with Trust policy. e. There were long periods when Mr Reid was not moved – there were episodes during 15/2/23 to 21/2/23 when Mr Reid was not documented to have moved for 5-10 hours. This is not best practice. f. Following a Tissue Viability Team assessment there was no follow up planned – this should have been planned to monitor wound progression. g. No photographs were taken between 8/2/23 and 21/2/23. The taking of photographs represents best practice to enable the progress and/or deterioration of a wound to be fully understood.
6	**ACTION SHOULD BE TAKEN** I acknowledge that following the internal investigation an action plan was developed and that the learning from this matter has extended to other areas of North Devon District Hospital and parts of the Exeter site. The evidence revealed that education around pressure ulcer relief is a constant piece of work with the tissue viability team often responding when an incident has been reported. I acknowledge that there is evidence to support the conclusion that the work done so far since Mr Reid's death has resulted in a reduction in the cases of serious pressure damage, but it is my judgement that the issues raised in this case warrant further consideration and wider dissemination across the trust and beyond to help improve outcomes for patients.

	(1) **Consideration should be given to reviewing the process of Managing and treating pressure ulcers in hospital and where necessary to provide training and education in Trust policies and best practice to staff across the entire Trust.** 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 4th 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 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	**SIGNED:**  **Mr Philip C Spinney** **HM Senior Coroner**