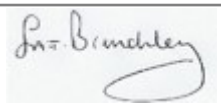
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST**
1	**CORONER** I am Simon Brenchley, Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 25 November 2024 I commenced an investigation into the death of Iris Joan CARTER. The investigation concluded at the end of the inquest on 10th April 2025 . The conclusion of the inquest was; Died from natural causes likely due to complications associated with her reduced mobility after an operation to stabilize a fracture.
4	**CIRCUMSTANCES OF THE DEATH** **On 1st October 2024, Iris, who had a complex medical history and a previous above knee amputation of her right leg, suffered a fall at home, sustaining a peri prosthetic fracture of her left distal femur. On 2nd October, she underwent a successful operation at the QEH in Birmingham to stabilize her fracture but her recovery including getting her back to her baseline mobility was affected by pain and by her developing a chest infection for which she was treated with a course of anti-biotics. On 27th October 24 once medically fit for discharge, she was transferred to the Ann Marie Howes inpatient Rehabilitation Unit where she received further treatment including for a Grade 4 pressure sore to her left heel which had developed during her inpatient stay at the QEH but which was not noted on the QEH inpatient records. Unfortunately, on 5th November she developed pneumonia and was admitted urgently to Birmingham Heartlands Hospital. She received treatment there for her pneumonia including IV antibiotics and although her condition initially stabilized, she suffered a significant and swift deterioration on 8th November, passing away that day in hospital.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Hospital Acquired Pneumonia** **1b** **1c** **1d** **II Recent Periprosthetic Fracture Stabilisation of Left Distal Femur (Operated 02/10/2024)**
5	**<u>CORONER'S CONCERNS</u>** 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. On her arrival at the Ann Marie Howes Rehabilitation Unit on 27th March 2024 Iris was assessed and found to have a Grade 4 Pressure Sore on her left heel which I was satisfied must have been present prior to her discharge the same day from the Queen Elizabeth Hospital. 2. I heard evidence during the inquest that Iris was at heightened risk of developing pressure sores given her co-morbidities and reduced mobility post her operation and that a Grade 4 pressure sore is the most serious type of pressure sore where bone is exposed and can therefore be at risk of infection. 3. However, apart from one entry on 13th October 2024 in the QEH electronic in patient noting records when it was recorded that Iris was complaining of pain on palpation of her left heel and a pillow was placed under her heel, there is no reference in the noting to it having been observed at any point that Iris had developed a pressure sore to her left heel during her admission at the QEH. 4. This leads to a concern that either the skin to her left heel was not being properly inspected or if it was that such inspections were not adequately noted in the electronic in-patient noting.
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 11 June 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: Family of Iris Carter Birmingham Community Healthcare Trust I have also sent it to the Medical Examiner, ICS and CQC, who may find it useful or of interest. 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	**16 April 2025**

	Signature:  **Simon Brenchley** **Assistant Coroner for Birmingham and Solihull**