Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Red Oaks Care Community**
1	**CORONER** I am Gordon CLOW, Assistant Coroner for the coroner area of Nottingham City and Nottinghamshire
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 17 October 2024 I commenced an investigation into the death of Maureen POWELL aged 95. The investigation concluded at the end of the inquest on 10 June 2025. The conclusion of the inquest was that: Maureen Powell died from severe frailty, a natural disease. The pressure ulcer she experienced contributed to the medical cause of death.
4	**CIRCUMSTANCES OF THE DEATH** After a long and active life, Maureen Powell suffered a series of health problems in the months leading up to her death, resulting in a very long stay in hospital. She had suffered a stroke and a fractured neck of femur, as well as other medical problems, and was unable to fully recover. She moved from hospital into a nursing home. Maureen Powell's death was from severe frailty but this was contributed to by a large and serious pressure ulcer. That ulcer developed and worsened whilst Maureen Powell was in a nursing home during the period following her discharge from hospital. It was the policy of that nursing home to provide a high standard of care for residents at risk of pressure damage as well as those who had suffered pressure damage. Suitable equipment and caring regimes were available to provide this support to reduce the risks of the damage worsening or to heal damage which had occurred. Many aspects of the care which was indicated for the pressure damage were not implemented. This more than minimally contributed to the development of the sacral pressure ulcer which, in turn, contributed to the death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. Repositioning was undertaken, but recording and implementation was, at times, patchy;

	2. There was widespread non-compliance with the regime of daily skin inspections in the period of time that Maureen was a resident at the Nursing Home. Not one skin inspection was recorded during Maureen's stay; 3. Care plans were not updated regularly in line with good practice and were not always updated when the circumstances required; 4. There was a delay in putting an appropriate bed surface in place; 5. On at least one occasion the airflow mattress was incorrectly adjusted, reducing its efficacy; 6. The family were not kept up to date about deterioration in the wound; 7. The referral to tissue viability was made too late as it occurred after the wound had got beyond the ability of the in-house nursing staff to manage and treat the wound; 8. No internal investigation was undertaken; 9. Key records were not kept or were lost or destroyed; 10. Inaccurate reports were made to the CQC and social care about the incidents; and 11. There was an apparent lack of clear guidance to staff as to what to do if or when pressure damage was identified.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 August 06, 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 **Red Oaks Care Community** I have also sent it to [redacted] **CQC - Care Quality Commission** **Sherwood Medical Partnership - Forest Town** **Nottinghamshire County Council** **Nottinghamshire Healthcare Trust - NHCT** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 11/06/2025**  **Gordon CLOW** **Assistant Coroner for** **Nottingham City and Nottinghamshire**