Tameside and Glossop
Integrated Care
NHS Foundation Trust

[redacted]
Chief Executive Officer
Tameside and Glossop Integrated Care NHS Foundation Trust
Silver Springs
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8th September 2025

FAO Mr Morris

HM Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
Cheshire
SK1 3AG

FURTHER INFORMATION, FOLLOWING THE INQUEST TOUCHING ON THE DEATH OF MRS VALERIE HAMPSON

[redacted]

I am writing to you following the inquest touching on the death of Mrs Valerie Hampson, which concluded on 11th June 2025.

Following the inquest, you raised some concerns that the Trust had not undertaken any serious incident investigation with a view to identifying if any learning could usefully be identified in the light of the progression of Mrs Hampson's left leg wound whilst under the care of the District Nurses. It was a further matter of concern for you that the court heard evidence that an Orthopaedic review undertaken in the Emergency Department on Mrs Hampson's initial attendance resulted in a recommendation that Mrs Hampson should be followed up in fracture clinic. For reasons which did not become clear during the inquest, the evidence of the consultant orthopaedic surgeon was that no such follow up appears to have taken place. In order to address the concerns you raise, I have set them out below.

CONCERN 1

Mrs Hampson sustained an injury to her knees following a traumatic fall at home which prompted her attendance to the Trusts' Emergency Department on 2nd October 2024. At the point of Mrs Hampson falling, she was not known to the District Nursing Service, however, had been intermittently know to the service since 2017.

Mrs Hampson referred herself to the District Nursing Service on 4th October 2024**.** At that point the injury described was that of a blister to her right knee, therefore the damage to Mrs Hampson's knee was already present at the point of self-referral. A home visit was then arranged for Mrs Hampson on 7th October 2024.

The Queens Nursing Institute Workforce Standards for District Nursing state that registered nurse visits should occur on every fourth visit to carry out the nursing process. Whilst healthcare support workers and nursing associates can be involved in the nursing process and play a vital role in the delivery/implementation of care, the assessment, planning and evaluation of care remains the responsibility of the registered nurse.

Mrs Hampson was seen by a combination of registered nurses, assistant practitioners and health care assistants and our local policy is for the registered nurse to attend every 3rd visit to ensure the care is led by a registrant. This is reflected and recorded in the attendance notes for Mrs Hampson.

Mrs Hampson's blister remained stable for several weeks until 29th October 2024 when concerns were raised by another community healthcare team regarding the wound and Mrs Hampson was visited by a District Nurse Team Leader. The wound was 60% granular and 40% sloughy and measured 100mm wide by 75mm length and 1.5mm depth. The wound was photographed, cleansed and redressed and a referral was made to the Tissue Viability Team (TVN). This is in line with the expectations of a District Nursing role. At the point of deterioration, the Divisional Nurse Director was also made aware of this and she triggered an urgent Tissue Viability review following a review of the case.

Mrs Hampson was then escalated to the Emergency Department on 30th October 2024 by a community practitioner and was reviewed by the Tissue Viability Nurses as an inpatient. She was reviewed by the surgical team and referred to the specialist plastics team at Wythenshawe.

Since the inquest we have revisit the care and treatment provided to Mrs Hampson. At the point the wound was noted to be deteriorating, Mrs Hampson was referred promptly back to the Emergency Department. The circumstances surrounding how the wound occurred and how it came to deteriorate did not fit the criteria for investigation in that:

- The wound was caused because of a traumatic injury following a fall which occurred whilst Mrs Hampson was not under the care of the District Nurses.
- Specialist opinion has been sought
- At the point the wound deteriorated it was promptly referred to TVN

If the Trust were to be self-critical, a referral could have been made 24 hours earlier, however, that would not prompt any formal investigation, but it would contribute to local learning.

Wound care, management and escalation is overseen by the Divisional Nurse Director for Integrated Tier Services. A meeting is held every Wednesday where pressure ulcers/moderate harm incidents are reviewed and advice provided. This was not considered a moderate harm incident.

As you will know, the Trust moved to the Patient Safety Incident Response Framework (PSIRF) in May 2024. This sets out the NHS's approach to developing and maintaining effective system and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This governance process is overseen by the Chief Nurse and Medical Director. Whilst the Trust do not consider that an investigation was needed in this instance, I want to reaffirm that this process allows families and patients to share their perspectives and will formulate part of the investigation/learning response which we take very seriously.

The learning and outcome for Mrs Hampson in regards to the District Nursing Services has been shared at a local learning level since this inquest and at the weekly team meetings and escalation huddles which are held every day at 1pm. Within the last 12 months, the service has introduced a high impact board where details of complex patients' needs are identified and shared. The service also participates in monthly Continuous Improvement Meetings (CIM) which enables lessons learnt and sharing to be cascaded across the Division. In addition, the Division also conduct monthly masterclass sessions by the Quality and Development Practitioner for the Intermediate Tier Services at the Trust. The masterclass sessions have a different theme each month based on previous incidents, safeguarding concerns or feedback from the coronial process. They are attended by all staff irrelevant of grade or role to ensure continued learning within practice.

CONCERN 2

As explained during the evidence, following Mrs Hampson's first attendance to the Emergency Department on 2nd October 2024 an x-ray was performed. The X-ray did not identify any fracture.

On a further review of the Mrs Hampson's records, there is no appointment that has been arranged for the out-patient fracture clinic. The discharge documentation states no mention of fracture clinic appointment. The follow up was that once discharged, care would continue under the District Nursing Service. Following Mrs Hampson's attendance on 30th October 2024 she was admitted and referred to Wythenshawe and she was managed as an in-patient in Tameside Hospital until she could be transferred to Wythenshawe on 1st November 2024. I am sorry that this information was not made clear to you during the inquest. I can confirm that there was no follow up appointment made in the fracture clinic for Mrs Hampson as no fracture was identified.

I do hope that this letter provides you with further reassurance following the inquest, however, should you have any queries arising from the content of this letter or require further information or clarification, please do not hesitate to contact Legal Services [redacted]

Yours sincerely,

[redacted]

Medical Director
On behalf of [redacted](Chief Executive Officer)
Tameside and Glossop Integrated Care NHS Foundation Trust