REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Secretary of State for Health and Social Care

CORONER

I am Chris Morris, Area Coroner for Greater Manchester (South).

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 20th February 2025, an inquest was opened into the death of Brenda Fisher who died at Stepping Hill Hospital, Stockport on 16th January 2025, aged 86 years. The investigation concluded with an inquest which I heard on 23rd June 2025.

The inquest heard evidence that Mrs Fisher died as a consequence of:

1)a) Pseudomonas aeruginosa sepsis;

b) Cellulitis from leg ulcers;

II Rhabdomyolysis following long lie; heart failure

At the end of the inquest, I recorded a conclusion of Accident.

CIRCUMSTANCES OF THE DEATH

Mrs Fisher died on 16th January 2025 at Stepping Hill Hospital, Stockport as a consequence of complications arising from wounds initially sustained in a minor accident at home which would not heal as a result of her complex underlying health problems. Mrs Fisher's death was contributed to by Rhabdomyolysis.

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. –

The court heard evidence that on her final attendance to hospital, Mrs Fisher was cared for in the Emergency Department's 'Rapid Assessment and Triage' Corridor for at least 23 hours before a bed was found for her.

Whilst the Trust has undertaken a number of steps locally to mitigate the risks associated with this practice, I am concerned that there remains a residual and inherent risk of death arising from

patients remaining for lengthy periods in areas not designed or intended for undertaking observations and providing care.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **22nd August 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, together with the family and Stockport NHS Foundation Trust.

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.

Dated: **27th June 2025**

Signature: Chris Morris, Area Coroner, Manchester South.