REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

The Chief Executive, Tameside and Glossop Integrated Care NHS Foundation Trust

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 28th February 2025, I opened an inquest into the death of Valerie Hampson who died at Willow Wood Hospice, Ashton-under-Lyne on 29th December 2024, aged 82 years. The investigation concluded with an inquest which I heard on 11th June 2025.

A post mortem examination determined Mrs Hampson died as a consequence of Non-Hodgkin's Lymphoma.

At the end of the inquest, I recorded a **conclusion of Natural Causes**.

CIRCUMSTANCES OF THE DEATH

Mrs Hampson died at Willow Wood Hospice, Ashton-under-Lyne on 29th December 2024 as a consequence of Non-Hodgkin's Lymphoma, having first been diagnosed with a low grade follicular Lymphoma in 2023.

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 in October 2024, Mrs Hampson sustained minor wounds to both knees in a fall outside her home. Mrs Hampson was later seen on a number of occasions in the Emergency Department and referred herself to the District Nurses on 4th October 2024 for wound care, remaining on their case load until her admission to Tameside General Hospital on 30th October 2024.

By the time Mrs Hampson's wounds were formally assessed in hospital by a Tissue Viability Nurse on 31st October 2024, the wound to her left knee was described as '*5.4cm x 13cm 10% necrosis (thick dark devitalized tissue) 40% slough (yellow devitalized tissue) 50% granulation tissue*.'

I am concerned that the Trust has 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 is a further matter of concern 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.

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 **13th 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 the legal representatives of the other Interested Persons.

I have also sent a copy to the Care Quality Commission, 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.

Dated: **18th June 2025**

Signature: Chris Morris, Area Coroner, Manchester South.