

Ms N J Mundy
H M Coroner
South Yorkshire (East District)
Coroner's Court and Office
Crown Court
College Road
Doncaster
DN1 3HS

Doncaster Royal Infirmary
Armthorpe Road, Doncaster,
South Yorkshire DN2 5LT

www.dbth.nhs.uk

Monday, 3 November 2025

Dear Ms Mundy,

I write in my capacity as Chief Nurse in response to the Regulation 28 Report issued following the inquest into the death of Mr Walter Colin Horton, who sadly passed away on 10 January 2025.

The report, addressed to [REDACTED], Chief Executive, was referred to me for a formal response, with support from [REDACTED], Nurse Consultant for Skin Integrity, and [REDACTED] Divisional Nurse for Medicine.

Please find below a detailed response to the matters of concern raised in the Prevention of Future Deaths Report (PFDR), including actions taken, timeframes, and rationale where no further action is deemed necessary.

1. Record Keeping - Falls

- There is no record or evidence of Mr Horton experiencing a fall during his admission.
- A falls risk assessment was completed in accordance with Trust policy, and no DATIX incident was submitted.
- The ward manager has no recollection of safety concerns during Mr Horton's stay.
- A mobility assessment was conducted; a hoist assessment was deferred to community services, with the care home agreeing to continue nursing in bed.
- Falls prevention remains a Trust-wide safety priority, with an action plan monitored through established governance processes.

2. Record Keeping and Wound Management

- Mr Horton was admitted with a pre-existing category 3 pressure ulcer, confirmed by photographic evidence.
- A safeguarding referral was made on admission in line with our Trust safeguarding procedures.
- Wound care was delivered in accordance with the specialist treatment plan and Trust policy, with documentation evidencing improvement.

- At discharge, there were no signs of infection or inflammation that could have contributed to sepsis.
- The Trust maintains a comprehensive skin integrity improvement plan, including regular audit, education, and training.

3. Handover Information on Discharge

- A discharge letter accompanied Mr Horton to the care home and was sent electronically to his GP, documenting clinical status and follow-up advice.
- A Trust-wide action group is in place to drive quality improvement in discharge processes, reporting to the Patient Safety Review Group.
- The Trust recognises that record keeping regarding communication at discharge is a key safety improvement priority.

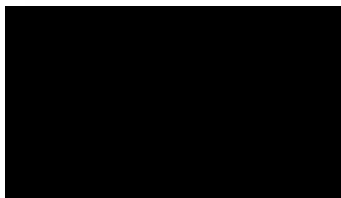
4. Aseptic Technique and Wound Cleanliness

- A detailed review found no evidence of breach in aseptic technique during wound care.
- Documentation confirms care was delivered in line with Trust policy, and the pressure ulcer improved during admission.
- There is no indication that wound management contributed to the development of sepsis.

Conclusion

The Trust has carefully considered the concerns raised and is committed to learning from Mr Horton's case. The actions outlined above are intended to strengthen patient safety and enhance discharge processes across the organisation. Please accept our sincere condolences to Mr Horton's family at this difficult time.

Yours sincerely



Chief Nurse
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust