MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

email: [redacted]

CORONER'S COURT AND OFFICE
CROWN COURT
COLLEGE ROAD
DONCASTER DN1 3HS

[redacted]

Date: 10 September 2025

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Mr Nick Mallaband , Acting Chief Medical Director, Doncaster & Bassetlaw NHS Foundation Trust

CORONER

1 I am Ms N J Mundy for South Yorkshire East

CORONER'S LEGAL POWERS

2 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 27 January 2025 I commenced an investigation into the death of Walter Colin HORTON. The investigation concluded at the end of the inquest . The conclusion of the inquest was

3 Narrative conclusion: *Walter Colin Horton died on 10 January 2025 in Benton House Care Home from an infected sacral pressure sore. The risk of the sore becoming infected was increased due to the absence of aseptic techniques being used in wound management.*

1a Sepsis

1b Advanced Sacral pressure sore

II Ischaemic heart disease

CIRCUMSTANCES OF THE DEATH

4 This case relates to the death of a 88 year old male who passed away in a Nursing Home on Fri 10 January 2025. Referred at the request of family due to safeguarding issues and pressure sores which they felt were associated with the death.

[redacted] Pathologist provided a COD as:
1a) Sepsis
1b) Advanced Sacral pressure sore
II) Ischaemic heart disease

5 **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. –

(1) Poor record keeping in regard to key areas of care namely falls and wound management and handover information on discharge

(2) A failure to understand or to follow use of aseptic techniques and cleanliness when managing wounds thus increasing the risk of infection.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you Nick Mallaband have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 30th October 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 and to the following Interested Persons, [redacted]. I have also sent it to The Secretary of State, Health & Social Care who may find it useful or of interest.

8 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.

10 September 2025

9 [redacted]

HM Senior Coroner for South Yorkshire (East)