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 5th February 2025, an inquest was opened into the death of Amanda Wood who died at Tameside Hospital, Ashton-under-Lyne on 3rd January 2025, aged 53 years. The investigation concluded with an inquest which I heard on 6th October 2025.

The inquest heard evidence that Miss Wood died as a consequence of:

1)a) Sepsis secondary to PEG tube (long term)

b) Crohn's disease

2) Stroke

At the end of the inquest, I recorded a Narrative Conclusion, to the effect that Miss Wood died as a consequence of Gastrostomy-related sepsis having been readmitted to hospital within 24 hours of discharge from the Emergency Department in the apparent absence of a sepsis screen being undertaken.

CIRCUMSTANCES OF THE DEATH

Miss Wood died on 3rd January 2025 at Tameside General Hospital at Tameside General Hospital as a consequence of sepsis secondary to a long-term Gastrostomy required due to Crohn's disease. Miss Wood had been treated for sepsis in the hospital between 21st – 27th December 2024 and discharged back to her nursing home once considered medically optimised. Following input of the Trust's Digital Health Service, Miss Wood attended the Emergency Department again on 28th December 2024 but was discharged. Miss Wood was brought back to the hospital for the final time on 29th December 2024.

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. –

Notwithstanding the ongoing work reported by the Trust in respect of the early identification and treatment of sepsis, I am concerned that there is no evidence of any sepsis screen being undertaken prior to Miss Wood's discharge from the Emergency Department on 28th December 2024.

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 **2nd December 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 Miss Wood's brother and the Care Quality Commission who may find the report to be useful or of interest.

The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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: **7th October 2025**

Signature: Chris Morris, Area Coroner, Manchester South.