

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Prestwick Care 2. Malhotra Group
1	CORONER I am Leila Benyounes, Assistant Coroner for the coronial area of Gateshead and South Tyneside.
2	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
3	INVESTIGATION and INQUEST On 12 March 2024 an investigation was commenced into the death of Pauline Stirling. The investigation concluded at the inquest on 9 October 2025. The conclusion of the inquest was a Narrative Conclusion: The Deceased died due to the effects of chronic infection due to pressure damage on a background of natural disease. The medical cause of death was: 1. Bronchopneumonia, chronic osteomyelitis secondary to pressure sores. 2. Alzheimers Disease, Lewy Body Dementia.
4	CIRCUMSTANCES OF THE DEATH The deceased, who had a medical history which included Alzheimers disease and Lewy Body Dementia, suffered a deterioration in her health in December 2023, which caused immobility, reduced nutritional intake and increased frailty. She developed multiple areas of pressure damage, from which she was at risk of developing, but which worsened due to lack of clear wound monitoring, wound care plans, and regular 2 hourly positional changes when she became immobile. A severe pressure wound was incorrectly categorised in a referral for specialist tissue viability nursing input, and other areas of pressure damage had not been assessed, photographed, and documented.

	A wound management and care plan was made by the tissue viability nurse comprising daily dressing changes, and 2 hourly positional changes with a 30 degree tilt. This plan was not followed consistently, which contributed to the worsening of the pressure damage and wounds from which healing could not be achieved. The Deceased continued to deteriorate died at 19.50 on 07/03/24 at Covent House Care Home in Gateshead.
h	<u>CORONER'S CONCERNS</u> During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. To date, the documentation for recording positional changes only requires care staff to input the position right, left, back, in chair with no reference to positional tilt to avoid pressure damage. 2. Whilst evidence was provided about the training requirements for full time members of nursing and care staff, to include mandatory full induction and refresher training, I am concerned having heard evidence that to adhere to the ratio of 2 RGNs per shift, agency nurses were regularly utilised, and no evidence about training requirements was provided. 3. Despite safeguarding referrals made due to concerns about wound management, and the issue of wound care, incorrect classification of pressure damage, and absence of expected documentation being raised initially by tissue viability nurses in January 2024, there is no evidence before the Court of training having been undertaken, including training offered by tissue viability nurses. The only training carried out was online webinar training by a former member of staff in March 2024. 4. There were candid acceptances that documentation was not completed to an accepted standard and there were gaps in the records. This is not the first inquest where acceptances were made, therefore I remain concerned that this is an ongoing issue despite evidence that this has been addressed with an auditing system.
6	ACTION SHOULD BE TAKEN

	In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, by 4 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.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: The Family of the Deceased ██████████ Birtley Medical Group Gateshead Health NHS Foundation Trust ██████████ 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 she 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.
9	LEILA BENYOUNES Assistant Coroner for Gateshead and South Tyneside 9 October 2025