	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Inspire You Care Ltd**
1	**CORONER** I am Ana Samuel Assistant Coroner for Birmingham and Solihull
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.
3	**INVESTIGATION and INQUEST** On 20 May 2025 I commenced an investigation into the death of Celia Marion PHILLIPS. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Died from natural causes contributed to by a malfunctioning ventriculo-peritoneal shunt.
4	**CIRCUMSTANCES OF THE DEATH** **The deceased had a complex medical history including normal pressure hydrocephalus, for which a Ventriculo-peritoneal shunt was inserted in October 2023 and revised in February 2024. In January 2025 she was hospitalised with discharge to a rehabilitation unit, following which she was discharged home with carers visiting four times a day due to her being bed bound. On the 27th April 2025, following a period of deterioration, the deceased was admitted to the Queen Elizbeth Hospital in Birmingham suffering from a probable chest infection, acute kidney injury and dehydration. CT imaging revealed a fractured shunt and increased ventricular volume following which a visual examination undertaken by the neurosurgical team discovered that the shunt had eroded through the skin and was visible, with some 6cm of tubing protruding. The erosion and protrusion had not been noted prior to this examination, either prior to her admission to hospital by family or carers or by hospital staff who saw her earlier on 27th April. Despite treatment the deceased continued to deteriorate and died on ward 513 on the 1st May 2025 at 12.03. Whilst the shunt malfunction and resultant protrusion did not directly cause her death it contributed to her neurological decline predisposing the deceased to infection and dehydration. The protruding shunt had been hidden by the deceased's hair and was not obviously visible.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Multiple Organ Failure** **1b Sepsis of Unknown Origin** **1c** **1d** **II Malfunctioning Ventriculo-Peritoneal Shunt (For Normal Pressure Hydrocephalus), Chronic Kidney Disease, Type 2 Diabetes, Frailty**
5	**<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 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. The deceased was bed bound. 2. On the 12th March the deceased's GP documented that she had pressure sores and stressed the importance of frequent repositioning, noting that she had carers who attended four times a day. 3. In both written, oral and documentary evidence provided by the carers there was no indication that repositioning had been undertaken; that there was any understanding of the need for repositioning to mitigate against the development of pressure sores; or that there had been training on pressure scores, skin assessment or re-positioning. 4. Whilst not causative of or contributory to death when admitted to hospital on the 27th April 2025 it was noted that the deceased had a DTI and a grade 1 pressure sore.
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, namely by 21 January 2026. 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: University Hospitals NHS Foundation Trust, [redacted], [redacted], CQC I have also sent it to the Medical Examiner, ICB, NHS England, 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. 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	**26 November 2025** Signature: 

	Ana Samuel **Assistant Coroner for Birmingham and Solihull**