Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Ignite Health and Homecare Services, 1c Lowesmoor Terrace, Worcester**
1	**CORONER** I am David REID, HM Senior Coroner for the coroner area of Worcestershire
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 25 March 2025 I commenced an investigation and opened an inquest into the death of Jean Alice WALDRON aged 79. The investigation concluded at the end of the inquest on 07 January 2026. The conclusion of the inquest was that Mrs. Waldron "died from natural causes, to which the effects of a long-standing traumatic spinal cord injury and a pressure ulcer contributed."
4	**CIRCUMSTANCES OF THE DEATH** Towards the end of 2024 Jean Waldron, who lived with a long-standing cervical spinal cord injury and a more recent diagnosis of vascular dementia, developed a sacral pressure ulcer, which was monitored and treated by district nurses. Around the beginning of March 2025 she developed a chest infection. Despite treatment, she continued steadily to decline, and died at her home in Worcester on 12.3.25.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) In her evidence at the inquest a carer from your agency, who was a Team Leader, gave evidence that: (a) she had read and understood an email from the District Nurse Clinical Lead, dated 15.1.25, which made clear that carers should not provide any care in relation to Mrs. Waldron's pressure sore as they did not have the correct licence to provide wound care; and (b) despite that clear instruction, she had on 3 separate occasions thereafter removed soiled wound dressings from the pressure sore and attempted to clean the wound with saline and gauze because she felt that it was in the deceased's "best interests" so to do. The lead Tissue Viability Nurse who gave evidence at the inquest said that the use of gauze was inappropriate and could have led to further adverse complications with the pressure sore. It is particularly concerning that a carer who was a Team Leader acted in the way

	described, and suggests that carers employed by your agency may not have received adequate training about: (a) the limits of the care which they are able to provide; and (b) the need to accept and follow advice given by specialist doctors and nurses at all times.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 March 05, 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 [redacted] **Worcestershire Acute Hospitals NHS Trust** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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.
9	**Dated: 08/01/2026** [redacted] **David REID** **HM Senior Coroner for Worcestershire**