REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, Mulberry Court Care Home CQC
1	**CORONER** I am Miss Sarah Wood, Assistant Coroner, for the coroner area of Nottinghamshire.
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 the 4th of February 2025, I commenced an investigation into the death of Ronald Colin Nelson. The investigation concluded at the end of the inquest on the 15th of January 2026 A narrative conclusion was given.
4	**CIRCUMSTANCES OF THE DEATH** Colin died from aspiration pneumonia which was caused by his advanced dementia. His advanced dementia led him to be non-verbal. He became bed bound on the 17th of October 2024 due to a respiratory infection and developed pressure sores as a consequence of this. He was treated for grade 2 pressure sores whilst in hospital and when discharged to his care home this deteriorated to a grade 3 and then a grade 4 causing sacral osteomyelitis. There were significant gaps in Colin's records at the care home and evidence a care plan was not followed leading to the deterioration of the pressure sores and the following infection which led to his final admission to hospital. He was admitted to Hospital on the 16th of December 2024 for the final time with suspected sepsis. He was diagnosed with aspiration pneumonia on background of advanced dementia. Colin's pressure sores had deteriorated to category 4 and sacral osteomyelitis was identified on scans. He had very little reserve to fight such infection by this time and died on the 26th of January 2025 at the Queens Medical Centre, Nottingham. It is my view that a care plan was not complied with and the records from the care home were vague and at times misleading.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows – i) That there remain potential issues of poor record keeping. ii) There are concerns over the level of compliance of care plans. In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action.
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 the 13th of March 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: 1. [redacted] Colin's wife 2. The Nottingham University 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	**15th of January 2026 Miss Sarah Wood**