REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS **BEING SENT TO:** **1. Department of Health and Social Care**
1	**CORONER** I am Mr Andrew Walker, Senior Coroner, for the coroner area of North London
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 12th November 2024 I commenced an investigation into the death of, Albert Thomas Bellingham aged 84. The investigation concluded at the end of the inquest on 25th February 2026 . The conclusion of the inquest was a consequence of inadequate preventative treatment, amounting to neglect, of a sacral sore. The medical cause of death was 1a Entercloster boltae bacteraemia, 1b sacral sore, 11 Odontoid peg fracture following fall in September
4	**CIRCUMSTANCES OF THE DEATH** Alfred Thomas Bellingham died in hospital on the 10th November 2024 from an infection that arose from a sacral pressure sore. On the 3rd of September 2024 Mr Bellingham was brought to an outpatient hospital appointment following up on concerns raised by symptoms that may be related to the narrowing of the canal in the bones of his neck. The previous appointment in February had seen Mr Bellingham grow more frail and had lost more of his mobility which had not found its way to the hospital notes. Mr Bellingham was seated in a hospital wheelchair waiting in a corridor opposite the room where he was to have his appointment. The doctor who was to see Mr Bellingham was running late, by about an hour and in this time a health care assistant checked on him every 5 to 10 minutes. When the last patient had been seen out of his office the doctor spoke to Mr Bellingham apologising for the delay and he returned inside to attend to paperwork before seeing Mr Bellingham. It is likely that Mr Bellingham tried to stand up to make his way into the room for his appointment and in doing so fell. Mr Bellingham had suffered a fracture that required a collar and was treated in hospital before being moved to a Care Home on the 16th October 2024. There was a really serious failure to provide appropriate nursing care to Mr Bellingham in that a preventable sacral pressure sore was allowed to develop to a point where Mr Bellingham had to

	return to hospital unwell with a pressure sore that had become black/grey in colour with a foul-smelling exudate that made the dressing wet. Despite every effort by the hospital Mr Bellingham died from a bacteraemia from the infected pressure sore.
5	**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 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. – Consideration of guidance to support interventionalist, supervisory role with appropriate training for doctors working in care homes when dealing with pressure sore.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organization has 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 Wednesday the 6th May 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 : Mr Bellingham's Family Care Home GP Surgery Hospital Trusts involved. 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 other 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.
9	**12th March 2026** [redacted]