REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Alison Mutch Senior Coroner, for the coroner area of Greater Manchester (South)
2.	**DATE OF REPORT** **15th May 2026**
3.	**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.	**THIS REPORT IS BEING SENT TO:** **1) Chief Executive Tameside NHS Foundation Trust** **2) The Brooke Surgery** You are under a duty to respond to this report within 56 days of the date of this report, namely by **10th July 2026**. I, the coroner, may extend the period if an appropriate application is made.

4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

5.	**SUMMARY OF CORONER'S CONCERN** This report is made in respect of a range of concerns arising from the evidence relating to provision of care by the District Nurses and the GP Practice.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 23rd October 2025, I commenced an investigation into the death of Edith Jones born on 22nd May 1932. The medical cause of her death was determined at inquest to have been: **1)(a)** heart failure on a background of an infected Grade 4 sacral pressure ulcer **II** Chronic kidney disease, Hypertension, Coronary Artery Atherosclerosis, Frailty

	At the end of the inquest, I recorded the following Narrative Conclusion: Died from natural causes exacerbated by the lack of oversight and management of the pressure ulcer in the community by the District Nursing Team.
8.	**CIRCUMSTANCES OF DEATH** Edith May Jones had limited mobility and a number of underlying health conditions including heart failure. She showed signs of sacral moisture damage and the Hyde district nursing team became involved in her care. By 12th August 2025 the wound was showing signs of slight improvement. Visits were reduced to weekly. The clinical rationale was not documented. It should have been. On 16th August 2025 she was visited and the wound had deteriorated. The next visit was scheduled for 21st August. The rationale for the delay until the next visit was not documented. It should have been. On 18th August the family requested an urgent visit due to concerns regarding the sacral wound. The visit did not take place until 19th August. There is no documented rationale for the delay in attending. This should have been documented. On 19th August the District Nurse who attended did not view the sacral wound. They should have. On 20th August the family raised further concerns about the wound and were told a District Nurse would visit on 21st August. On 21st August the dressing was changed. The wound was found to have deteriorated to a large ungradable pressure ulcer since the last time there had been any input on 16th August. On 22nd August and 23rd August the nurses attending did not document their observations of they wound. They should have. By 25th August the wound had deteriorated further. By 26th August she had deteriorated further. On 29th August she was admitted to Tameside General Hospital and treated for an infected stage 4 pressure ulcer. Despite being given intravenous antibiotics for 5 weeks she did not improve and became increasingly frail. She died at the Stamford Unit on 17th October 2025. A post mortem concluded that she had died from heart failure exacerbated by the strain of dealing with the infected grade 4 pressure ulcer.

9.	**CORONER'S CONCERNS** During the course of the inquest, I heard evidence 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. The quality of the District Nursing team documentation was poor. Consequently, it was difficult to understand the steps taken and the rationale for actions; 2. There was little evidence of oversight by District Nursing Team managers of how complex cases such as Mrs Jones were being managed; 3. There was no prompt escalation of her case by the District Nurses when the situation deteriorated; 4. The District Nursing gateway referral system had a triage process that did not identify or manage proactively her deteriorating condition. 5. The GP practice did not have an effective system to promptly triage referrals from the 111 service or information provided by a patients family.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: The family, North West Ambulance Service and City Care Solutions. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

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