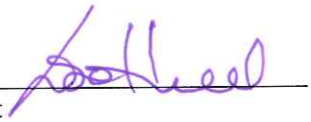
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: St Giles Nursing Home**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 09/08/2017 I commenced an investigation into the death of Mildred Joan Griffiths. The investigation concluded at the end of an inquest on 16th November 2017. The conclusion of the inquest was Natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The deceased fell from a chair at her home in May 2017 resulting in a fracture of her left distal femur, above a previous knee replacement. She was admitted to Birmingham Heartlands Hospital where she was noted to have a grade 2 sacral pressure sore. She was discharged to St Giles nursing home for care and rehabilitation on 02/06/17. She was largely bedbound and had poor nutrition and was unable to tolerate re positioning which caused the sore to deteriorate. Despite treatment she collapsed in the early hours of 03/08/17 and was declared deceased soon after arrival at hospital.. Following a post mortem, the medical cause of death was determined to be: 1a ISCHAEMIC HEART DISEASE 1b CORONARY ARTERY DISEASE 2 CARCINOMA OF LUNG WITH PNEUMONIA, PERFORATED DUODENAL ULCER WITH EARLY PERITONITIS, SACRAL 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 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 pressure sore risk tool used in the home is the Braden Score. The community Healthcare Trust use the Walsall score – which is nationally recognised. I note the Braden score does not take into account any existing lesion when calculating the risk which means it may under estimate the risk. In addition the Braden score calculates in an opposite way to the Walsall score – thus a low score is high risk in the Braden score, but low risk in the Walsall score. This can lead to confusion between professionals and the home should consider changing to the Walsall score.
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 12th January 2018. 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:- Family and Birmingham Community Healthcare NHS Foundation Trust 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. 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	17/11/2017 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**