REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, The Dudley Group NHS Foundation Trust.**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 20 August 2017, I commenced an investigation into the death of Mr Philip John Powell. The investigation concluded at the end of the inquest on 30 November 2017. The conclusion of the inquest was a short narrative conclusion of: Mr Powell Died after developing sepsis when a pressure sore became infected and deteriorated rapidly from a grade 3 to grade 4. The cause of death was: 1a Sepsis and Bronchopneumonia 1b Infected Sacral Pressure Sore and Buttock Abscess
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Powell was an 83 year old gentleman who had a medical history including Parkinson's disease, dementia and history of previous strokes. ii) He lived at home and was cared for by his family with support of Community nurses. iii) In July 2017 he started to develop an uncategorised stage 3 pressure ulcer and moisture lesion. iv) He was reviewed by a tissue viability nurse on the 18 July 2017 and Debrisoft which is anti-bacterial and used in the treatment of wounds wasn't available at the time and the nurse placed a request for more supplies. v) No Debrisoft was in fact ordered. The pressure ulcer was then cleaned and dressed and managed with Flaminal Hydro and allevyn instead. vi) By the 4 August there were now clear signs of infection and the ulcer had become malodorous and inflamed. vii) By the 7 August the ulcer had deteriorated rapidly and he was admitted to Russells Hall Hospital where a 7cm cavity was identified and suspected

	sepsis. viii) Despite further treatment his condition continued to decline and sadly he died on the 16 August 2017 after developing sepsis and bronchopneumonia due to 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 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. Evidence emerged during the inquest that there were delays in ordering Debrisoft which would have helped in managing the wound. 2. In addition, there was evidence of poor communication and poor systems in place in ordering Debrisoft with confusion about the process and overall responsibility.
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 Although an internal investigation was completed, it did not address the issue of the delays in ordering Debrisoft and you may consider it is important to revisit this area to look at the systems in place.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 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. 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	**30 November2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**