H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive of Gloucestershire Care Services NHS Trust, Edward jenner Court, 1010 Pioneer Park, Gloucester Business Park, Brockworth, Gloucester GL3 4AW**
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 24th June 2016 I commenced an investigation into the death of Rose Workman. The investigation concluded at the end of the inquest on the 22nd June 2017. The conclusion of the inquest was a natural and narrative conclusion. The medical cause of death was 1A septicaemia, 1B bronchopneumonia, infected ulcers
4	**CIRCUMSTANCES OF THE DEATH** Rose Workman "Rose" was a 76 year old woman. She suffered with blood pressure and bilateral leg ulcers. She had been admitted to hospital on three occasions since December 2015 for a head injury, an angioplasty and abnormal blood results. From November 2015 Rose's leg ulcers were being cared for by District Nurses , her GP and she attended outpatient appointments with a Vascular Consultant. Rose remained at high risk of deteriorating pressure damage. She was advised how to mitigate the risk factors. Rose was often resistant to this advice. The leg ulcers remained problematic. District Nurses were attending to dress the ulcers. However there were periods of time when Rose's overall condition was not being tracked. This was due to a number of reasons including staff shortages and District Nurses being unclear as to what assessments had to be undertaken. Following her discharge from hospital on the 13th May 2016, Rose's wound appeared much better. Her diet remained poor. On the 9th June 2016 Rose's condition was declining. Medical advice was sought, and the following morning family members requested an urgent home visit from the GP. The GP attended later that day and admitted Rose to hospital suffering with general decline, dehydration and leg ulcers. Antibiotics and further investigations were commenced. Her observations remained stable. At approximately midday on the 16th June Rose's condition suddenly deteriorated. The Acute Care response team instigated a management plan which included an urgent CT scan. The scan indicated that Rose was suffering from a pneumonia. Despite treatment, Rose's condition continued to deteriorate, and she passed away at 6.15am on the 17th June 2016.
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. Whether the district nursing service employs sufficient measures to ensure that patients are effectively monitored of their ongoing condition(s).
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 4pm 31st August 2017. 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] (2) [redacted] Kingsholm Surgery, Alvin Street, Gloucester, GL1 3EN (3) [redacted] Head of Legal Services, Legal Services Dept, West Block, Cheltenham General Hospital, Sandford Road, Cheltenham, GL53 7AN 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	Dated 6th July 2017 Signature Ms K Skerrett Senior Coroner for Gloucestershire