REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Chief Executive,** **St George's Hospital,** **Blackshaw Road,** **Tooting,** **London.** **SW17 0QT.** 2. **Head of Physiotherapy,** **St George's Hospital,** **Blackshaw Road,** **Tooting,** **London.** **SW17 0QT.**
1	**CORONER** I am Dr Fiona Wilcox, HM Senior Coroner, for the coroner area of Inner West 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 7th January 2014 I commenced an investigation into the death of **Mr John Patrick Fox, aged 93years.** The investigation concluded at the end of the inquest on 4th march 2014. The conclusions of the inquest were as follows: ***Injury or disease causing death:*** **I(a) Ventricular arrhythmia** **(b) Ischaemic heart disease, atrial fibrillation, heart failure and aortic regurgitation** **(c) pneumonia** **II Fractured neck of femur (surgery 23/12/2013) and osteopenia.** ***How, when and where Mr Fox came by his death:*** **Mr Fox sustained an accidental fall at his home address on 22/12/2013. He fractured his left neck of femur and was admitted to St Georges Hospital. Despite all active treatment for his fracture and underlying heart problems, he died on 01/01/2014.** ***Conclusion of the coroner as to the death:*** **Accidental fall in combination with severe underlying natural disease.**
4	**CIRCUMSTANCES OF THE DEATH** Evidence was taken from his daughter that Mr Fox had a severe kyphosis and

	ankylosing spondylitis. This would have meant that he was at high risk of chest infection post operatively, making early mobilisation and physiotherapy especially important. During his in patient stay there were 3 bank holidays and a weekend, during which the access to physiotherapy was limited to an on call service only.
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. – **That there is a reduced level of physiotherapy services on bank holidays and weekends, increasing the risk of post operative complications developing in vulnerable patients.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 30th April 2014. 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] 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	**5th March 2014** **Dr Fiona Wilcox** **HM Senior Coroner Inner West London.**