Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mount Vernon Hospital (Minor Injury Unit)** Rickmansworth Road Northwood, HA6 2RN
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater 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 the 13th November 2014 I opened an inquest touching the death of Amanda Susan Harris , aged 62 years old. The inquest concluded on the 26th May 2015. The conclusion of the inquest was "Narrative", the medical case of death was 1a Massive Pulmonary Thromboembolism 1b Immobility following fracture of the right metatarsal bone. And under paragraph 2 Obesity
4	**CIRCUMSTANCES OF THE DEATH** On the 18th October 2014 Amanda Susan Harris fell at her care home and fractured a bone in her right foot. Mrs Harris was taken to the minor injuries unit where a cast was placed on her foot and an appointment made to a fracture clinic, there being no such facility at the Minor Injuries Unit. Mrs Harris returned to her care home where she was unable to get out of bed. On the 1st November 2014 she was found having died in her bed by care home staff.
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 Mrs Harris was not seen by a doctor before leaving the Minor Injuries Unit, that anticoagulant therapy was not considered and that when fixing an appointment for the fracture clinic the potential immobility from the injury and the effects of that immobility were not assessed.

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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 Tuesday 5th August 2015 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;- Representatives of the 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	**10th June 2015** [redacted]