ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Heart of England NHS Foundation Trust Good Hope Hospital**
1	**CORONER** I am Margaret Joy Jones, Assistant Coroner, for the coroner area of 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 2 February 2015 I commenced an investigation into the death of Lottie Reid, aged 95 years. The investigation concluded at the end of the inquest on 23 June 2015. The conclusion of the inquest was that the deceased died from bleeding duodenal ulcers on a background of other significant natural disease. Her death was probably accelerated by a short time due to the bleeding being exacerbated by a recognised complication of antigoagulant drug therapy.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was 95 years of age with a background of atrial fibrillation, hypertension, congestive heart failure, hypertension, chronic kidney disease and hypothyroidism. She had been hospitalised in December 2014 following a fall and discharged for a second time to Perry Trees Intermediate care centre on the 7th January 2015. Her medication included enoxaparin and aspirin. She became more frail in the weeks prior to her death. On the 29th January 2015 she was readmitted to Good Hope Hospital, Rectory Road Sutton Coldfield with hematemesis and melena. She deteriorated quickly and died at 12 o'clock on the 29th January 2015. Post mortem examination found significant natural disease including previously undiagnosed duodenal ulcers and cirrhosis of the liver.
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) That following discharge from Good Hope Hospital to Perry Trees Intermediate Care Centre the Printed Electronic Prescribing Medication Admin Chart did not mirror the medication referred to in the Discharge Letter and Prescription. (2) There did not appear to be a protocol in place whereby such discrepancies could be easily checked and this appeared to be especially difficult to do at weekends
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 20 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. The Family of the deceased, NewLaw Solicitors, DAC Beachcroft LLP, Capsticks, MDU Services Limited 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	**25th June 2015** **Signed**