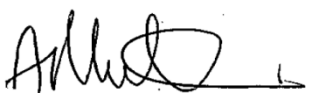
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Belong Central Office, Pepper House, Market Street, Nantwich, Cheshire CW5 5DQ **2.** [redacted] Inspector, Bolton, Wigan and Salford Team, Adult Social Care Directorate, Care Quality Commission, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA
1	**CORONER** I am Alison Mutch Assistant Coroner for the Coroner Area of Manchester West
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 12th October 2015 I commenced an investigation into the death of Mary Walker aged 91. The investigation concluded at the end of the inquest on 11th April 2016. The conclusion of the inquest was that she died of natural causes namely bronchopneumonia.
4	**CIRCUMSTANCES OF THE DEATH** Mary Walker resided at [redacted] She developed dementia and was cared for by her family. She was admitted to Royal Albert Edward Infirmary, Wigan after a stroke. She was discharged home but fell and was readmitted to hospital. She had fractured her ramus pubic. She was discharged to Belong Village, Atherton on 14th September 2015. She was seen by two nurse practitioners and the District Nurse. She was thought to have a urinary infection and was prescribed antibiotics. On 9th October she was put to bed. She was checked at 10pm, 1am and 4.30am. On 10th October at 5.45am she was found dead. She had died of bronchopneumonia.
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) At the inquest there was no specific evidence about what was revealed in the night time checks that had been carried out upon the deceased. There was a global summary stating the times at which checks had been carried out but there was no information as to what the patient's condition was at the checks. This procedure requires review. (2) During the inquest there was a lack of clarity in relation to the procedures to be followed by Care Assistants when they wanted to escalate health concerns. This system requires review.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe 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 16th June 2016. 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:- [redacted] Son of Mary Walker [redacted], Wrightington, Wigan & Leigh NHS Trust 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** **21st April 2016**	**Signed**  **Alison P Mutch** **Assistant Coroner**