	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Blackpool Teaching Hospitals NHS Trust**
1	**CORONER** I am Dr James Adeley, senior coroner/area coroner/assistant coroner, for the coroner area of Preston and West Lancashire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 29/09/2014 I commenced an investigation into the death of Dorothy Imisson, aged 82. The investigation concluded at the end of the inquest on 05/04/2016. The conclusion of the inquest was: Dorothy Imisson died on 9 August 2014 at Cleveleys Nursing Home from a naturally occurring stroke caused by atrial fibrillation. Dorothy Imisson's death was contributed to by an absence of pressure care planning by qualified staff resulting in a premature development of severe skin ulceration, a shortening of life and increased pain and suffering.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are fully set out in the attached Summing Up and Conclusion.
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) No appropriate care plan was developed by the District Nursing Service. (2) The District Nursing Service are compromising patient care by not following NMC guidance or record keeping (3) The District Nursing Services are compromising patient care by not following NICE guidelines.
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 .7 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, to the family, to the relevant CCGs and the CQC. For the avoidance of doubt the document is only provided to the CCGs and the CQC for information purposes and to inform their future care provision negotiations. 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 Signature ..... For PRESTON AND WEST LANCASHIRE