Stuart P G Fisher
HM Senior Coroner
County of Lincolnshire

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. **Dr Neill Hepburn, Medical Director, United Lincolnshire Hospitals NHS Trust, Robey House, Lincoln County Hospital, Greetwell Road, Lincolnshire, LN2 5QY**
1	**CORONER** I am Paul S Cooper, Assistant Coroner for the Coroner's area of Lincolnshire.
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 3rd February 2015 I commenced an investigation into the death of Dorothy Doreen BREISLIN, age 89. The investigation concluded at the end of the inquest on 29th November 2017. The conclusion of the inquest was Narrative.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to the Pilgrim Hospital, Fishtoft on 18th January 2015 following a fall at home. She was initially treated for a pulmonary embolism. A later diagnosis revealed a fracture of the 8th rib on the right side that led to massive bleeding and eventually her demise.

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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 The incident date was 27th January 2015. The Incident Review Report was not received in this office until 10th August 2017. Why the delay? 2 S.13 recites an apology has been provided verbally and in writing. The families ask who made the apology. Also, when and where as they are adamant they have never received one. 3 [redacted] confirmed on oath that none of the Action Plan referred to in the Appendices at 3 have been implemented. If not, in view of the Incident Date why not? Copy of the Incident Review Report is attached for ease.
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 29th January 2018. 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.

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8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. 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	**Date: 4th December 2017** **PAUL S COOPER** ..... **H M ASSISTANT CORONER FOR THE COUNTY OF LINCOLNSHIRE**

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