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. **Rosewood Lodge Nursing Home** **9 Uphill Road North** **Weston-super-Mare** **BS23 4NE**
1	**CORONER** I am Dr. S. Fox, Assistant Coroner, for the area of Avon.
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 17th May 2017 an investigation was commenced into the death of **Irene Winifred BAKER**, Aged **84**. The investigation concluded at the end of the inquest on 11th December 2017 The medical cause of death was: Ia Acute on chronic post-operative cardiac failure Ib Coronary arterial atherosclerosis II Recent fractured neck of femur, repaired surgically Healed myocardial infraction Cirrhosis of liver, diabetes mellitus The conclusion of the inquest was **Natural causes**
4	**CIRCUMSTANCES OF THE DEATH** Mrs. Baker died following an operation on a fractured hip which the evidence suggested occurred at Rosewood Lodge Nursing Home. However the Nursing Home had no record of it. The fracture was recorded under section 2 of the cause of death.
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 revision of the mobility care plan in response to monthly reviews documenting a deterioration in mobility in November and December 2016; 2. No monthly mobility reviews were undertaken in January and February 2017; 3. A failure to contact the GP or call an ambulance in response to a documented inability to weight-bear 12th - 23rd April 2017

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 6th February 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons – 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	**11th December 2017** **Dr. S. Fox**