for Plymouth Torbay and South Devon

| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>**THIS REPORT IS BEING SENT TO: The Care Quality Commission,**Citygate, Gallowgate Newcastle upon Tyne, NE1 4PA |
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| 1 | **CORONER**<br><br>I am Ian Michael Arrow, the Senior Coroner for Plymouth Torbay and South Devon |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 16/06/2015 I commenced an investigation into the death of Doreen Willis, 80. The investigation concluded at the end of the inquest on 6 June 2017. The conclusion of the inquest was NARRATIVE The deceased has a history of strokes due to clotting. Her risk of stroke was approximately 9% per year. This risk was mitigated by taking the medication Rivoroxiban For a period of time she did not receive Rivoroxiban. The absence of Rivoroxiban may have contributed to her death. She died at Belle Vue Care Home, Paignton on 9 June 2015. Massive Cerebral Vascular Accident |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>Reporting as safeguarding issues (as discussed by next of kin originally).Lady was admitted to TBH on 17/05/15 with a stroke then transferred to Brixham Hospital on 22/05/15. On 03/06/15 she was discharged to Belle Vue for end of life care. Prior to that she had been at Primley Court Nursing Home since 02/04/15 having been discharged there from Brixham Hospital. Vaguely aware that at Primley Court she was not given her Rivoroxiban. Had been seen by her previous surgery and notes not yet with new surgery [redacted] states cause of death is1a) Stroke |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>At the conclusion of the Inquest I asked [redacted] who presented evidence in connection with the Root Cause Analysis Report to summarise the key areas of learning identified. I am attaching her letter to my office of the 22 June 2017.<br><br>I would ask you please to have regard to those recommendations when your organisation carries out future inspections of care homes.<br><br>Would you kindly review the nature of CQC inspections in the light of [redacted] key learning points. |

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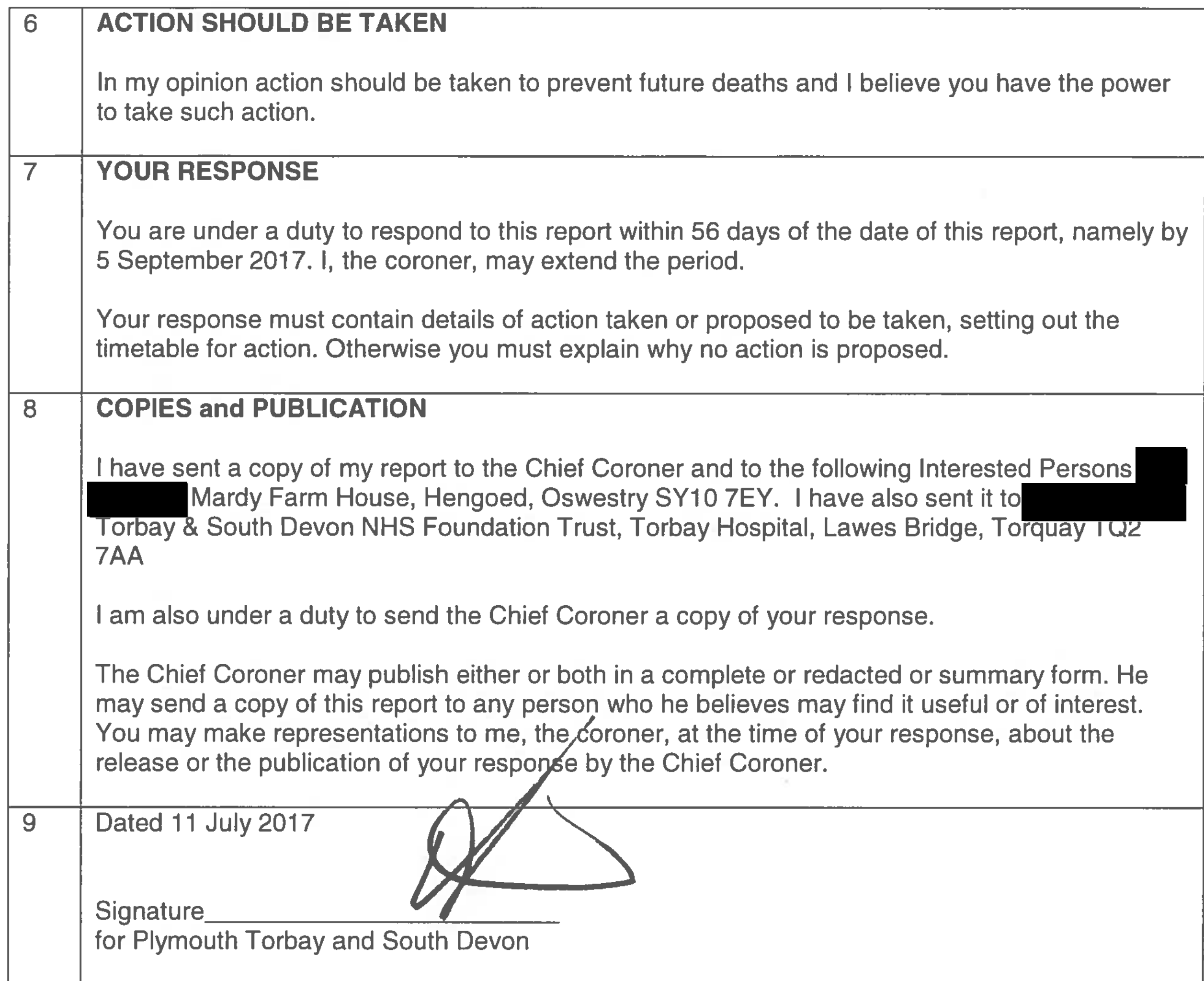

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 5 September 2017. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED] Mardy Farm House, Hengoed, Oswestry SY10 7EY. I have also sent it to [REDACTED] Torbay & South Devon NHS Foundation Trust, Torbay Hospital, Lawes Bridge, Torquay TQ2 7AA<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 11 July 2017<br><br>Signature____________________________<br>for Plymouth Torbay and South Devon |

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