REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Clinical Commissioning Group**
1	**CORONER** David Urpeth, Assistant Coroner, South Yorkshire (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. (1) Where – (a) A senior coroner has been conducting an investigation under this Part into a person's death (b) Anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and (c) In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner
	INVESTIGATION and INQUEST On 22nd May 2015 I commenced an investigation into the death of John Henry Robinson (aged 84). The investigation concluded at the end of the inquest on 21st August 2015. The narrative conclusion of the inquest was that: *On 21st April 2015, Mr Robinson went into Broomcroft House Nursing Home for respite care. It was subsequently recognised that he required admission to a Psychiatric bed but no suitable bed was available. On 9th May 2015 Mr Robinson was admitted to the Northern General Hospital, Sheffield where he remained until his death on 18th May 2015.* The medical cause of death was found to be; 1(a) Acute Kidney injury 1(b) Dehydration 1(c) Severe Depression 2 Dementia, Chronic Kidney Disease, Ischaemic Heart Disease and Diabetes

4	**CIRCUMSTANCES OF THE DEATH** On 21st April 2015, Mr Robinson went into Broomcroft House Nursing Home for respite care. It was subsequently recognised that he required admission to a Psychiatric bed but no suitable bed was available. On 9th May 2015 Mr Robinson was admitted to the Northern General Hospital, Sheffield where he remained until his death on 18th May 2015.
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. – The evidence at inquest suggested Mr Robinson required a psychiatric bed on Dovedale, but no such bed was available. His condition deteriorated and he ultimately died. The concern is whether sufficient resources are available in this area.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 Wednesday, 18th November 2015. I 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 (who are not under a duty to respond): [redacted]**(family)** [redacted]**(family)** [redacted]**(Clinical Commissioning Group)** 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	**1st September 2015** **David Urpeth**