# Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

**REGULATION 28 REPORT TO PREVENT DEATHS**

**THIS REPORT IS BEING SENT TO:**

**1 [redacted] – Chief Executive-Bradford Royal Infirmary**
**2 [redacted] – Clinical Director –Bradford Royal Infirmary**

**1 CORONER**

I am Dr Anthony Howard, Assistant Coroner for the area of West Yorkshire Western Division.

**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 Seventh August 2019 I commenced an investigation into the death of Susan Margaret ROBERTS aged 62. The inquest concluded and at the end of the inquest the conclusion was:

I a Necrotising Fascititis

I b Recreational Intravenous Drug Abuse

**4 CIRCUMSTANCES OF THE DEATH**

Susan Roberts died on the 15 July 2019 at approximately 4 am at Bradford Royal Infirmary of Necrotising Fasciitis, having been admitted on the 13 July 2019 without an appreciation at the time or thereafter of the diagnosis or need for surgical intervention.

**5 CORONER'S CONCERNS**

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

1. There has been lack of timely and effective hand over been the different surgical specialties, with an absence of formal protocol.

2. That when asked for help at the time and during the investigation, there seems to have been a lack of engagement from the Plastic Surgeons. They failed to join the Orthopaedic Registrar in theatre at the time of the incident and then failed to attend the round table analysis at part of the SI investigation.

**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 30th July 2021. 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 the next of kin who may find it useful or of interest.

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**

**Dr Anthony HOWARD**
**HM Assistant Coroner for**
**West Yorkshire Western Coroner Area**
**Dated: 07 June 2021**