ANNEX A

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:** **North Essex Mental Health Partnership Trust**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex
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 [26 January 2016] I commenced an investigation into the death of Margaret Ann Richardson. The investigation concluded at the end of the inquest on 17 August 2016. The conclusion of the inquest was a Narrative conclusion :- . *On 5 September 2015, the deceased was admitted to Kitwood ward St Margaret's Hospital Epping. She suffered a number of falls and she died on 25 January 2016 in Princess Alexandra Hospital Harlow. At least the last fall may have contributed to her death. There were failings in the implementation of the North Essex Mental Health Partnership Trust's Prevention and Management of Falls Policy in Kitwood ward.* The cause of death was 1a) Bilateral pneumonia 11) subdural haematomata, ischaemic heart disease
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered at least 5 falls while a patient in Kitwood Ward St Margaret's Hospital Epping and she died in Princess Alexandra Hospital Harlow after the last fall.
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., it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) a robust, comprehensive Action Plan with timescales` needs to be put in place, following the findings of the Serious Incident Investigation and the evidence heard during the inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 16th October 2016. 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 – Leigh Day, solicitors for the family] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. 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	**19.08.2016** **Mrs Caroline Beasley-Murray – HM Senior Coroner**