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:** **1. The CHIEF EXECUTIVE of DONCASTER & BASSETLAW NHS FOUNDATION TRUST** **2. -** **3. -**
1	**CORONER** I am GEOFFREY M. SAUL Assistant Coroner, for the coroner area of SOUTH YORKSHIRE (EAST) DISTRICT
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 15TH MARCH, 2013 THE SENIOR CORONER commenced an investigation into the death of ROSEMARY BRONWYN FERGUSON, AGE 55 YEARS. The investigation concluded at the end of the inquest on 12TH DECEMBER, 2013. The conclusion of the inquest was THAT SHE DIED OF NATURAL CAUSES. THE MEDICAL CAUSE OF DEATH WAS 1a SUDDEN UNEXPECTED DEATH IN EPILEPSY.
4	**CIRCUMSTANCES OF THE DEATH** **ROSEMARY BRONWYN FERGUSON** had a long-standing past medical history of epilepsy. On 8th March, 2013 she was admitted into the emergency department of Doncaster Royal Infirmary after sustaining a head injury in a fall close to her home. There, she was referred to the Rapid Assessment Project Team who assessed her as not being fit for discharge in view of her high risk of further falls, due to mobility and cognition issues. This concern was shared by another Social Worker and a recommendation was made to hospital staff that Ms Ferguson should remain in hospital over the weekend to allow the issue of her safety, primarily from falls, to be addressed. Despite these recommendations, the attending clinician concluded it was appropriate for her to be discharged into the care of her friend [redacted] and this discharge took place on either Friday 8th March, 2013 or Saturday 9th March, 2013. Notification of the discharge was not given to Social Services, so no emergency support measures were put in place. There was a difference of perception between the clinicians and [redacted] as to his role and [redacted] did not interpret that he was meant to maintain constant contact with Ms Ferguson over the weekend to ensure her safety. On 11th March, 2013, Ms Ferguson was found deceased alone at her home. The autopsy revealed no significant injuries and the cause of death was given as 1a Sudden unexpected death in epilepsy.
5	**<u>CORONER'S CONCERNS</u>**

	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) The social workers left work on Friday 8th March, 2013 believing that, following their recommendations, Ms Ferguson would remain in hospital over the weekend and accordingly they did not put into place any support measures for her. The clinician's decision to discharge her before support measures could be put in place was not communicated to Social Services. If it had been, this would have given an opportunity for them to take urgent supportive action. As it transpired, Ms Ferguson died from Natural Causes rather than, for example, Injuries sustained in a further fall, or a deterioration of her earlier head injury, but I apprehend danger in the future if discharge occurs contrary to Social Service recommendations without the discharge being notified to them. (2) The clinician discharged Ms Ferguson based on clinical issues and NICE guidelines. She was discharged to the care of her friend [redacted] The only conversation between the clinicians and [redacted] was a telephone call in which it was arranged for Ms Ferguson to be driven straight to his home on leaving hospital. This duly took place, but [redacted] did not understand that the clinician expected him to remain in her company for at least the next 24 hours in order to watch for any significant changes in her condition and accordingly, he did not remain with her constantly. There was clearly a difference of perception about his role, possibly as a result of a lack of clarity in the conversation between himself and the clinician. I am concerned that a repetition of this in other cases may lead to danger. (3) The Hospital Notes were scanty and there appear to be material omissions to record important decisions such as a detailed note of the telephone call between [redacted] and the clinician, properly timed and recording clearly what was intended. Further, it was difficult to trace from the Notes, the actual day of discharge, the clinician believing it to be the 8th March and [redacted] believing it was the 9th March. Some computer records were presented to the Court suggestive of a discharge on the 8th March, but this information appears to be missing from the actual hand-written Notes. I am concerned that such problems with communication can lead to misunderstandings to the detriment of all concerns.
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 17 March 2014. I, the Assistant 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 Mr Mike Pinkerton, Chief Executive, Doncaster & Bassetlaw NHS Foundation Trust and to the brother of the deceased, [redacted] and [redacted], Solicitor for the Social Services. 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	**[DATE)** **[SIGNED BY CORONER]**