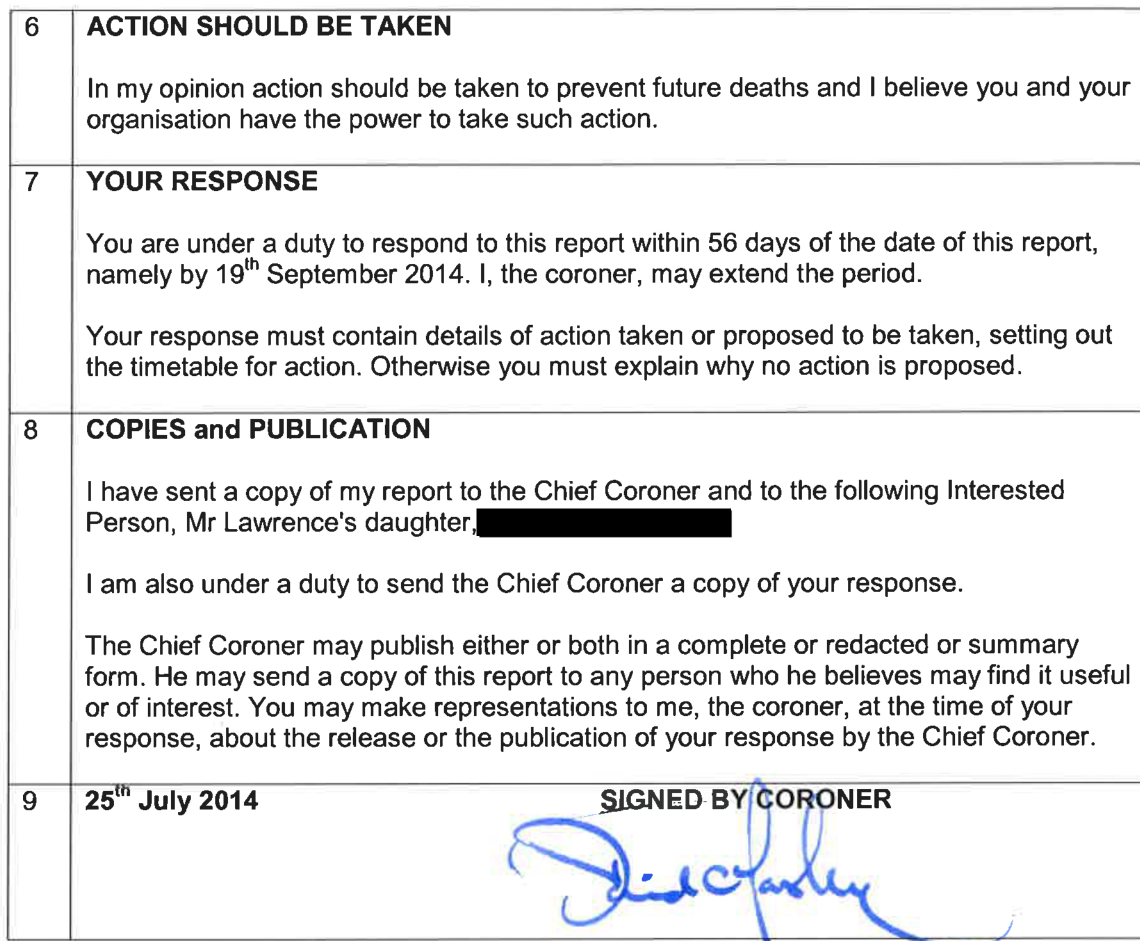
ANNEX A

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:** **[redacted] - Manager - Alexandra Rose Care Home, 358 Havant Road, Portsmouth PO6 1NE**
1	**CORONER** I am David Clark Horsley, HM senior coroner for the coroner area of Portsmouth and South East Hampshire.
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 30th May 2013 I commenced an investigation into the death of Charles Cecil Lawrence, aged 89. The investigation concluded at the end of the inquest on 7th July 2014. The conclusion of the inquest was Mr Lawrence died due to an Accident. The medical cause of this death was: Ia: Spinal Cord Compression Ib: Fractured Thoracic Vertebrae 2: Congestive Cardiac Failure and Pneumonia
4	**CIRCUMSTANCES OF THE DEATH** On 2nd April 2013 Charles Cecil Lawrence fell in the residential home where he lived. He was visited by his GP who noted no apparent injury to Mr Lawrence. Mr Lawrence fell again later that day but his GP was not recalled. By 11th April 2013 Mr Lawrence was in increasing distress and his condition deteriorated and his GP admitted him to Queen Alexandra Hospital, Portsmouth, where he was diagnosed as having sustained an untreatable spinal injury. He died at Queen Alexandra Hospital on 23rd May 2013 at 06.40 hours.
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. – Alexandra Rose Care Home does not have a protocol of calling out a doctor to examine a resident who suffers more than one fall in a 24 hour period.



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 19th September 2014. 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 Person, Mr Lawrence's daughter, 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	**25th July 2014** **SIGNED BY CORONER**