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. [redacted] Directors of Springfield Care Home**
1	**CORONER** I am Miss Stephanie Haskey, Assistant Coroner, for the Coroner area of Nottinghamshire
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 15th May 2015 an Inquest was commenced into the death of Thomas Farrell, who died on 16th July 2014 at Queen's Medical Centre, Nottingham of Respiratory Failure as a result of Bronchopneumonia as a result of Emphysema. A Conclusion of Natural Causes was recorded.
4	**CIRCUMSTANCES OF THE DEATH** Mr Farrell died whilst a resident at Springfield Care Home, Nottingham. Shortly before his death he became unwell with a chest infection and was visited by his GP, who prescribed antibiotics, which were given. The Home had taken responsibility for the administration of Mr Farrell's prescription medications, including those he entered the home with, as well as the antibiotics. His condition worsened and he was admitted to hospital in the early hours of 16th July 2014, where he died the same day.
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: 1. That the Home did not know the true extent of the prescription drugs which were indicated for Mr Farrell while he was a resident, having not approached Mr Farrell's GP for a full record. The result of this was that the prescription drugs aspirin, senna, doxacil and omeprazole were not given. Whilst in the event this did not cause or contribute to his death on 16th July 2014, the risk of such an omission causing death in other circumstances is clear.
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 **9th September 2015**. 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: 1. [redacted] 2. [redacted] I have also sent it to: The Care Quality Commission and Nottingham City Council Safeguarding Adults 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	**[DATE]** **[SIGNED BY CORONER]** **14th July 2015** **Stephanie Haskey**