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:** **Anglian Community Enterprise**
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 16 May 2016 I reopened the inquest touching upon the death of Martha Ann Davies. The cause of death was *1a) subdural haematoma 1b) multifactorial fall 11)fracture neck of femur (treated)* The jury's conclusion at the end of the inquest was a narrative conclusion:- *Martha Ann Davies died as a result of an accident. We agree that Mrs Martha Ann Davies was given adequate and appropriate care at Colchester Hospital University Foundation Trust, that Mrs Martha Ann Davies did not receive adequate care and appropriate treatment at Clacton District Hospital and that this may have contributed to her death*
4	**CIRCUMSTANCES OF THE DEATH** The deceased, a very fit 98 year old lady, fell at home and was admitted to Colchester Hospital on 11 October 2015 where she received surgery for a fractured hip. On 7 November she was then transferred to Clacton Hospital for rehabilitation. On 17 November she suffered a fall and she was transferred to Colchester Hospital on 19 November. She died there on 29 November.
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. – Cont……

	(1) Serious failings in communication between shifts, with senior staff, and at multi-disciplinary meetings (2) Over reliance upon agency staff and on junior staff to make decisions (3) Lack of prompt response to the patient's deteriorating state. (4) Lack of engagement of ward staff and ward manager (5) Failings in the documentation
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 11 November 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 – the family, the Care Quality Commission. 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	**16 September 2016** **Caroline Beasley-Murray**