	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. BMI Health Care**
1	**CORONER** I am Dr James Adeley, senior coroner, for the coroner area of Preston and West Lancashire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 07/04/2015 I commenced an investigation into the death of Sally Ann Tooze Froggatt, aged 52. The investigation concluded at the end of the inquest on 03/05/2016. The conclusion of the inquest was: Sally Ann Tooze Froggatt died on 6 April 2015 at Royal Lancaster infirmary following multiple missed opportunities by clinicians to treat her high risk of venous thromboembolism that would have saved her life. Further opportunities for live saving measures were lost both at discharge and during a cancelled follow up telephone call from a clinician.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are fully set out in the attached Summing Up and Expressions of Concern.
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. a failure to comply with the Duty of Candour 2. inadequate training of staff 3. corporate pharmacy guideline documentation that appears to contradict the NICE guidance referred to in other corporate literature 4. failure of BMI nursing staff to raise known risk factors with consultants
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 5 July 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, to the family, to the relevant CCGs and the CQC. For the avoidance of doubt the document is only provided to the CCGs and the CQC for information purposes and to inform their future care provision negotiations. 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	Dated 11 May 2016 Signature ---------- For PRESTON AND WEST LANCASHIRE