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:** **Princess Alexandra Hospital**
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 13 September 2019 I commenced an investigation into the death of Ann Margaret Smith. The investigation concluded at the end of the inquest on 3 November 2020. The conclusion of the inquest was that she died as a result of an accident contributed to by natural disease. The cause of death was 1a) subdural and intracerebral haemorrhage 11) Hypertensive Heart Disease and Bronchopneumonia
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to Princess Alexandra Hospital on 8 September 2019 and on 9 September she suffered an unwitnessed fall. She sustained a head injury and she died on 13 September 2019
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. There was uncertainty as to how to deal with the anti-coagulation aspect of the deceased's care in the wake of the fall. There is the lack of a local protocol (part of the Falls Policy) for the management of the sub-group of patients over 65 on anticoagulants and being given treatment dose of clexane for another clinical reason eg suspected pulmonary embolus, who sustain head trauma.
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 the 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 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	**5 November 2020 Caroline Beasley-Murray senior coroner Essex**