Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Berkeley Home Health**
1	**CORONER** I am Jason PEGG, Area Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 08 July 2020 I commenced an investigation into the death of Barbara PROUDLOVE aged 92. The investigation concluded at the end of the inquest on 12 July 2022. The conclusion of the inquest was that: See box 4
4	**CIRCUMSTANCES OF THE DEATH** The deceased died on 4th July 2020 at Southampton General Hospital, Tremona Road, Southampton, Hampshire having developed pneumonia in consequence of cardiac failure and dementia. The deceased had elevated levels of morphine and lorazepam within her body, how that came to be cannot be ascertained, which caused the deceased to be unconscious and contributed to the death. There was a delay in summoning medical assistance for the deceased which together with the deceased's frailty contributed to the death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) The Berkeley Home Health carer did not identify that the deceased was unconscious in good time; there was delay by the carer in summoning medical assistance. The evidence of the carer demonstrated a lack of training, skills and understanding in being able to reasonably identify a medical emergency and how to respond to a medical emergency. My concern is that such carers lack the necessary training and skills when tasked with caring for others in the same position as the deceased.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or

	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 September 06, 2022. 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 [redacted] I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 12/07/2022**  **Jason PEGG** **Area Coroner for** **Hampshire, Portsmouth and Southampton**