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 Central North West London NHS Foundation Trust** **2 Milton Keynes Council – Adult Social Care**
1	**CORONER** I am Tom OSBORNE, Senior Coroner for the coroner area of Milton Keynes
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 12 August 2022 I commenced an investigation into the death of Clifford William ROSE aged 80. The investigation concluded at the end of the inquest on 14 October 2022. The conclusion of the inquest was that: *Clifford William Rose died on the 10th August 2022 at Florence Nightingale Hospice, Aylesbury. He had suffered a burn on his leg from an electric blanket that became seriously infected. He had his leg amputated on 4th August 2022. Failures in the assessment of his care needs and to escalate concerns of his deteriorating health and his own self neglect contributed to his death.*
4	**CIRCUMSTANCES OF THE DEATH** Clifford William Rose died on the 10th August 2022 at Florence Nightingale Hospice, Aylesbury. He had suffered a burn on his leg from an electric blanket approximately 6 weeks prior that became seriously infected. He had his leg amputated on 4th August 2022. His cause of death was reported to the Coroner as: 1a) Multi Organ Failure 1b) Myocardial Infarction 2) Ischaemic Heart Disease, Full Thickness Burn to Left Lower Leg
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: During the course of the evidence at the inquest it became apparent that detailed assessments of the needs of very vulnerable and perhaps elderly patients are being carried out over the telephone. In this particular case, it lead to the deceased confirming that he was able to dress himself and that he was eating and drinking regularly. This was far from the correct position. I believe that consideration should be given to put in place a system whereby all assessments are carried out face-to-face and where appropriate should involve another member of the family.

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 December 14, 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 **Family of Mr Rose** I have also sent it to **MK Together Partnership** **BLMK Clinical Commissioning Group** 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: 20/10/2022**  **Tom OSBORNE** **Senior Coroner for** **Milton Keynes**