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 Tanglewood Cloverleaf Care Home**
1	**CORONER** I am Paul COOPER, HM Assistant Coroner for the coroner area of Lincolnshire
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 22 October 2019 I commenced an investigation into the death of Lilian SHEARING aged 84. The investigation concluded at the end of the inquest on 13 September 2022. The conclusion of the inquest was that: The deceased died on 29th September 2019 in Lincoln County Hospital, Greetwell Road, Lincoln after being admitted there for unrelated medical treatment .
4	**CIRCUMSTANCES OF THE DEATH** The deceased died on 29th September 2019 in Lincoln County Hospital, Greetwell Road, Lincoln after being admitted there for unrelated medical treatment .
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) Upon admission on 11th July 2019 to your care home it was recorded at handover the deceased had a poor fluid intake. Despite this no risk assessment was undertaken. Omissions were also made from the fluid intake chart. It was conceded at Inquest today by your regional manager that the deceased's fluid intake was approximately 25% of where it should have been before her admission to hospital on 23rd August 2019 due to dehydration. Policies/assessments were clearly not in place to cover this eventuality. What are your current policies re risk assessments for fluid and nutrional intake?
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 November 08, 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 I have also sent it to [redacted] 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: 14/09/2022** **Paul COOPER** **HM Assistant Coroner for** **Lincolnshire**