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:** **1. Orchard 2000 Pharmacy** **2. General Pharmaceutical Council**
1	**CORONER** I am Mr Edward Steele, assistant coroner, for the coroner area of East Riding of Yorkshire and City of Kingston Upon Hull.
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 10 February 2023, I commenced an investigation into the death of Harold Wilberforce, aged 87 years. The investigation concluded at the end of the inquest on 7 July 2023. The conclusion of the inquest was Accidental Death. Box 3 of the Record of Inquest read: Mr Wilberforce had an unwitnessed fall on 16 January 2023 at his home address, [redacted]. He suffered a left hip fracture, was taken to hospital and died of bronchopneumonia. His medical cause of death was recorded as: **1a** Bronchopneumonia **1b** Left hip intracapsular neck of femur fracture (operated) **1c** Fall **II** Chronic Obstructive Pulmonary Disease, Dementia, Cardio-renal Syndrome.
4	**CIRCUMSTANCES OF THE DEATH** Mr Wilberforce had a fall at his home address on 16 January 2023. An employee from a pharmacy delivery centre located him and assisted him to a chair. He was complaining of a leg injury and resisted her efforts to call an ambulance. The emergency services were not called. A note was left by the pharmacy delivery agent to say that Mr Wilberforce had had a fall. She left the premises. Mr Wilberforce was then located, after having suffered a further fall, by his neighbour much later the same evening. He had suffered a broken hip and was taken to hospital. In hospital, Mr Wilberforce contracted bronchopneumonia. He died on 28 January 2023.

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) The pharmacy delivery agent attended upon Mr Wilberforce at his home address to deliver his prescription. He had fallen inside the home address and support was provided to him by her. Mr Wilberforce had resisted her attempts to contact the emergency services. Mr Wilberforce was also moved, with the assistance of the prescription delivery agent, from the floor without having been subjected to a medical examination. The prescription delivery agent was, further, unaware of the status of Mr Wilberforce in respect of his dementia. (2) Evidence was provided on behalf of the pharmacy that there was no training provided to staff members in respect of how to deal with and what actions should be taken when a service user is found to have had a fall at their home address by a pharmacy delivery agent. Evidence was also heard that the majority of service users were elderly persons. (3) I am concerned that a lack of clarity exists in respect of the roles and responsibilities of persons attending upon the home addresses of elderly service users, particularly in the context of what action should be taken when someone is found to have fallen.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 4th September 2023. 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 of Harold Wilberforce. 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	**[DATE]** **[SIGNED BY CORONER]** ***10th July 2023*** ***Edward Steele, Assistant Coroner***