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. Chief Executive Officer Princess Alexandra Hospital NHS Trust**
1	**CORONER** I am SONIA HAYES, area 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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 7 July 2023 I commenced an investigation into the death of Margaret Ann PILGRIM, AGE 88. The investigation concluded at the end of the inquest on 5 June 2024. The conclusion of the inquest was 1a Congestive Cardiac Failure and Bronchopneumonia, 2 Frailty, Fall with a Fractured Clavicle Natural Causes contributed to by a Fractured Clavicle
4	**CIRCUMSTANCES OF THE DEATH** Margaret Ann Pilgrim died of Congestive Cardiac Failure and Bronchopneumonia at the Princess Alexandra Hospital on 29 June 2023 in a background of frailty. Mrs Pilgrim sustained a fractured clavicle in an unwitnessed fall at home on 3 June 2023 and was discharged from hospital on 4 June. Mrs Pilgrim's fractured clavicle was not on her discharge summary and her GP prescribed analgesia on 6 June. Mrs Pilgrim declined rapidly on 10 June with delirium and again on 16 June and had been treated with antibiotics. A scan on 19 June showed no evidence of pneumonia or malignancy and Mrs Pilgrim remained unwell and further tests were completed. Mrs Pilgrim was admitted into hospital and despite treatment continued to decline with intermittent delirium. Mrs Pilgrim was placed on end-of-life care.
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 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. – Mrs Pilgrim's collapse at home was multifactorial due to natural causes however, she sustained a fractured clavicle that was reported on her X-Ray during her admission to hospital. This was not noted, and Mrs Pilgrim was discharged. (1) The Trust did not treat the patient for the fracture who was discharged with no pain relief or consideration of care package

	(2) The Discharge Summary omitted to inform the patient, her family or her GP of the fracture and no follow-up in the fracture clinic was booked (3) The fracture was only confirmed when the GP raised the concerns of the family with the Trust and the GP arranged analgesia, social care contact and follow-up for the fracture clinic.
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 5 AUGUST 2024. 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 Mrs Pilgrim. I have also sent it to the Care Quality Commission who may find it useful or of interest. 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	**10 JUNE 2024** S. M. Hayes **HM Area Coroner for Essex**