## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 Northampton General Hospital** |
| **1** | **CORONER**<br><br>I am Elizabeth WHEELER, Assistant Coroner for the coroner area of Northamptonshire |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 22 September 2023 I commenced an investigation into the death of Linda Christine FARMER aged 67. The investigation concluded at the end of the inquest hearing on 2 April 2025 at Northamptonshire Coroner's Court. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>The medical cause of death was:<br>I(a) Bronchopneumonia<br>(b)<br>(c)<br>(d)<br>II Liver cirrhosis with hypoalbuminemia, COPD, poor nutritional status<br><br>The Box 3 findings of the record of inquest were:<br><br>Linda Farmer died at Northampton General Hospital on 22 August 2023. She had been admitted on 19 August, very unwell, and was swiftly place on a palliative pathway. She died as a result of bronchopneumonia, her death being hastened by other underlying medical conditions and her poor nutritional state.<br><br>She had had a previous admission to the hospital from 27 June – 16 August. Throughout this admission, her albumin levels had been low, and were consistently falling. At the time of her discharge on 16 August, the cause of this low albumin had not been fully investigated, but this was not probably causative. For at least the four weeks before her discharge on 16 August, Mrs Farmer's oral intake was very low.<br><br>Additional information for the purpose of this report is that:<br><br>When Mrs Farmer was re-admitted on 19 August, the clinicians caring for her identified concerns with the care provided in the admission from 27 June – 16 August, namely, in relation to the low albumin levels. These concerns were notified to the Family, and raised with the Medical Examiner at the time |
| **5** | **CORONER'S CONCERNS**<br><br>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. |

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| | The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>Not investigating care concerns raised by clinicians employed by the Trust in August 2023, compounded by not following the recommendation in the Trust's own Structured Judgement Review (2024) to carry out a "detailed investigation" into the care concerns raised. The absence of such investigations, having been identified by Trust processes as having been recommended, means that the care concerns raised have not been investigated, and any underlying system issues contributing to these have not been identified or resolved. This means they are at risk of occurring again, putting patients' lives at risk. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by May 30, 2025. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>**Northampton General Hospital**<br><br>I have also sent it to<br><br>[redacted]<br><br>who may find it useful or of interest.<br><br>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.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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: 04/04/2025**<br><br>  <br>**Elizabeth WHEELER**<br>**Assistant Coroner for Northamptonshire** |