## 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 FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Chief Executive of Essex Partnership University NHS Trust** |
| 1 | **CORONER**<br><br>I am STEPHEN SIMBLET KC assistant coroner, for the coroner area of Essex. |
| 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 [DATE] I commenced an investigation into the death of Carol Taylor, aged 75. The investigation concluded at the end of the inquest on 12th June 2025. The conclusion of the inquest was death was due to natural causes, the medical cause of death being a pulmonary embolism. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Carol Taylor was a detained psychiatric patient being treated on a ward for elderly patients. When she was found unresponsive in her bed during the night, the alarm was raised and a number of people attended to try to resuscitate her. There were also some concerns and criticisms of the resuscitation efforts, including raised at the time by the ambulance service personnel. On the facts of this case, any such failings did not play a part in the death and further, the Trust concerned has tried to improve the situation by providing better training and better prioritisation of this. Additionally, at least one of those employed health care workers was not up- to- date on her basic life support training. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) There is no system that prevents staff that are non- compliant with mandatory training, including basic life support training, from being able to work on EPUT in- patient wards.<br>(2) This is a particular concern generally, but especially in hospitals such as St Margaret's where at least some of the wards specialise in treating elderly patients who are likely to be at greater risk of medical collapse than the general population. |

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| 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 8th August 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>(i) [redacted] (husband of deceased).<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<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. 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 | **12th June 2025** |