REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Department of Health

1 CORONER

I am Mr Andrew Walker, senior coroner for the coroner area of Northern London

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 the 21 November 2024 commenced an investigation into the death of, Jacqueline Aarons, aged 60. The investigation concluded at the end of the inquest on 29 October2025. The conclusion of the inquest was Consequences of an unrecognised but symptomatic umbilical hernia. The medical cause of death was 1a Aspiration, 1b Strangulated umbilical hernia, 1c Downs Syndrome.

4 CIRCUMSTANCES OF THE DEATH

On the 19th November 2024 Jacqueline Aarons died at her Care Home from the consequences of a strangulated umbilical hernia.

Miss Aaron had become unwell with symptoms of vomiting after breakfast on the 17th November 2024.

The staff, none of whom were medically trained, called 111 and an Out of Hours doctor called the care home, felt that the patient had gastroenteritis and gave advice for better management of the patient. The Care Home doctor spoke to the staff the next morning and arranged for a Rapid Response nurse who attended and was reassured that Miss Aarons appeared to be settling. The nurse spoke to a doctor at the surgery before providing written advice to the staff when they may need to contact 999

Miss Aarons become more unwell, and an ambulance was called and attended on the morning of the 19th of November 2024.

The cause of the vomiting after breakfast on the 17th November 2024 is likely to be a partial obstruction related to the hernia which is likely during the early hours of the 19th November 2024 to have progressed to a complete obstruction leading to aspiration of stomach contents.

Had Miss Aaron been admitted to hospital at any point from when the vomiting started to the point at which she collapsed and stopped breathing at the Care Home it is likely that she would have survived.

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. -

Concern that there should be a recognised lower threshold for hospital admission for patients with learning disability

There should be a fact to face consultation by a doctor.

Following any consultation there should be written instructions including safety netting advice, set out in such a way that they may be understood and acted upon by staff who may not be medically trained.

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 Thursday 08 January 2026 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:

- 1. The family.
- 2. Representatives of the interested persons

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 other 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.

9	DATE: 10 November 2025