01 Background:

What is a Regulation 28?

Regulation 28 is the regulation that applies where a coroner is under a duty to make a report. In this regulation, a reference to “a report” means a report to prevent other deaths.

A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation.

02 Why it matters:

This regulation applies where a person is under a duty to give a response to a report to prevent other deaths made in accordance with paragraph 7(1) of Schedule 5.

The response must be provided to the coroner who made the report within 56 days of the date on which the report is sent.

The response to a report must contain —
(a) Details of any action that has been taken or which it is proposed will be taken by the person giving the response or any other person whether in response to the report or otherwise and set out a timetable of the action taken or proposed to be taken; or
(b) An explanation as to why no action is proposed.

03 What next?

The coroner must send a copy of the report to the Chief Coroner and every interested person who in the coroner’s opinion should receive it including the appropriate Local Safeguarding Children Board where the coroner believes the deceased was under the age of 18. Chief Coroner may **publish** a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit.

04 Statistics

In the Rochdale Borough

Over the last 3 years HMR received 7 requests for Regulation 28 responses -

- 5 included GPs
- 1 Care Home / Council
- 1 Acute Trust

05 Local learning

From Regulation 28 issued to GPs
Lack of GP training on Autism
Lack of GPs
Lack of awareness of psychological psychiatric impact of tinnitus
Lack of referral Pathways
Delay in access to RAID in out of hours
Confusion regarding pathways for GP to follow
NICE guidelines not followed
Communications between GPs and nurses not sufficient
Lack of effective communication and shared records.

06 National Learning:

- Poor record keeping
- Missed diagnosis
- Not following NICE 2005 cancer guidelines
- Lack of continuity of care
- Over prescribing pain killers
- Failure in the management of anti-coagulant therapy
- Lack of GP appointments
- No clinical record made
- Poor clinical assessment

07 Further information?

www.wwl.nhs/about_us/coroners_regulation_28_reports.aspx

https://www.judiciary.gov.uk

RBSAB ROCHDALE BOROUGH SAFEGUARDING ADULTS BOARD

RBSCB ROCHDALE BOROUGH SAFEGUARDING CHILDREN BOARD