The Office of Tom Osborne
Her Majesty's Senior Coroner for Milton Keynes

Civic Offices, 1 Saxon Gate East, Milton Keynes, MK9 3EJ

Our Ref: TRO/FT
Your Ref: 0000000
Reply To: Coroner
Direct Line: [redacted]
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Mr Joe Harrison
Chief Executive
Milton Keynes General Hospital
Standing Way
Eaglestone
Milton Keynes
MK6 5LD

23rd September 2013

Dear Sir,

Re: Regulation 28 Report to Prevent Future Deaths

I, as the Senior Coroner for the Coroner Area of Milton Keynes, 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.

On 12th February 2013, I commenced an investigation into the death of Sally King. The investigation concluded at the end of the inquest on 10th September 2013. The conclusion of the inquest was that Sally King fell from her chairlift on the 22nd December 2012, she was admitted to Milton Keynes Hospital where she was diagnosed with a fractured femur and ribs. I concluded that she died as result of an accident.

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –
(1) Mrs. King was a patient in the hospital for over three weeks and despite numerous attempts to involve the Pain Team they proved unsuccessful and she was not seen by the team during her admission.

(2) [redacted] a Consultant Orthopaedic Surgeon, in his evidence told me, "after three weeks of asking, the Respiratory Team eventually agreed to take over Mrs. King's care. However her transfer was delayed due to lack of beds on ward 16." Mrs. King was eventually transferred on the 6th February, the very day that she died. It would seem that she was not being cared for and treated on the appropriate ward or department.

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th November 2013. I, the coroner, may extend the period.

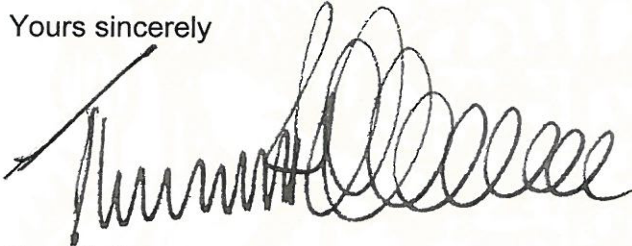
Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. I have sent a copy of my report to the Chief Coroner and to the family as properly Interested Persons .I have also sent it to Care Quality 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.

I await hearing from you with your response.

Yours sincerely



Tom Osborne
Her Majesty's Senior Coroner for Milton Keynes

This report is being sent to:

- **Family of Sally King**
- **Chief Coroner**
- **Care Quality Commission**
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