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

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

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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 4th February 2013, I commenced an investigation into the death of Yvonne Sydney Annie Perry. The investigation concluded at the end of the inquest on 20th September 2013. The conclusion of the inquest was a narrative conclusion:

> Yvonne Sydney Annie Perry fractured her left hip following a fall at home on 17th December 2012. The possibility of a fracture was recognised by the radiologist on 19th December 2012 but the radiology report was not acted upon until 4th January 2013 when she was readmitted to Milton Keynes General Hospital unable to weight bear. She developed a severe urinary tract infection and died of sepsis on 2nd February 2013.

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) That the x-ray taken of Mrs. Perry's hip, reported on by the consultant radiologist on the 19th December 2012, was not acted upon until the 3rd January 2013. It was recognised that the Hospital "do not have a robust process for tracking that the emergency department consultants have looked at the radiology reports." Without such a system I believe further deaths may occur in the future.

(2) The GPs who attend the Windsor Intermediate Care Unit do not have access to the electronic hospital notes and records and those witnesses from WICU who attended the inquest considered that such access would improve the care afforded to patients. Similarly without access to the patients notes further deaths may occur in the future.

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 Mrs Perry**
- **Chief Coroner**
- **Care Quality Commission**
- [redacted]