REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **East Kent Hospitals University** **NHS Foundation Trust** **Trust Office** **Kent & Canterbury Hospital** **Ethelburt Road** **Canterbury** **CT1 3NG**
1	**CORONER** I am Rachel Redman, Senior Coroner, for the Coroner area of Central and South East Kent.
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 19th February 2014 I commenced an investigation into the death of Margaret Joy Easterfield. The investigation concluded at the end of the inquest on 19th February 2014. The conclusion of the inquest was that Margaret Joy Easterfield died as a result of the unintended consequence of necessary surgical treatment
4	**CIRCUMSTANCES OF THE DEATH** Margaret Joy Easterfield required a reversal of Ileostomy loop. She developed peritonitis after requiring readmission to hospital after the surgery and subsequently died there.
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 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:- I am concerned that Mrs Easterfield underwent surgery on 26th October 2012 following which there was an anastomotic leak. She was discharged from hospital on the 30th October and was readmitted on 31st October, becoming profoundly unwell in the afternoon of the 3rd November and dying on the 4th November. I consider that a leak of ileo-ileal anastomosis is relatively rare and raises the question of technical error on the part of the surgeon. Because of my concern about the incidences of an anastomotic

	breakdown, I am raising this matter with you as I believe you can carry out action to prevent further death.
6	**ACTION SHOULD BE TAKEN** To monitor incidences of an anastomotic breakdown within the Surgical Directorate at East Kent Hospitals NHS Trust.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th April 2014. 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:- [redacted] – Deceased's brother Clyde & Co – [redacted] 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.
9	**DATE: 03rd March 2014 SIGNED :**