REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT is being sent to: **Pauline PHILIP** **Chief Executive** **L & D University Hospital** **Lewsey Road** **Luton** **LU4 4DZ**
1	**CORONER** I am **Mr Tom OSBORNE,** Senior Coroner for the Coroner Area of Bedfordshire and Luton.
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. **http://www.legislation.gov.uk/ukpga/2009/25/schedule/5**
3	**INVESTIGATION and INQUEST** On the 30th day of October 2013 I commenced an Investigation into the death of **Sari Marlene KEEN** aged 80 years. The Investigation concluded at the end of the Inquest on 19th March 2014. The Conclusion of the Inquest was that on the 23rd of October 2013 the deceased underwent surgery at the Luton & Dunstable Hospital, but subsequently developed peritonitis and died on the 24th October 2013. The medical cause of death being: I (a) Faecal Peritonitis (b) Colon Anastomotic Leak (c) Bowel Surgery for Tumours II Lung Fibrosis
4	**CIRCUMSTANCES OF THE DEATH** **Sari Marlene KEEN** underwent surgery at the Luton & Dunstable Hospital on the 23rd October 2013 to remove tumours from her colon.

	She was kept in recovery until 20:30 hours whereupon she was transferred to Ward 22. She had a leak from her anastomosis of faecal matter that caused peritonitis and she went into shock and died at 08:55 hours on 24th October 2013 following cardiac arrest. There was a failure to recognise her deteriorating condition and a failure to escalate her care to an appropriate level, which resulted in a lost opportunity to render further medical treatment. There was also a failure to alert the Hospital Crash Team when her blood pressure became unrecordable.
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: (1) The first matter of concern was that three witnesses who gave evidence, two Senior Nurses and one Doctor, told me that on the night that Sara died there were insufficient members of staff available to deal with the caseload of patients and this was not unusual. They felt overwhelmed and yet unable to escalate the care. (2) It was apparent that many Senior and Junior Members of Staff were not aware that an 'un-recordable blood pressure' was a 'medical emergency' and should have resulted in a crash call going out for immediate resuscitation. Perhaps the Protocols for the Crash Team need to be reviewed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of the Luton & Dunstable University Hospital, have 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 **12th JUNE 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 Person(s): [redacted] (sister of the deceased) 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	**Dated this 16th April 2014** **.....** **Tom OSBORNE** **Senior Coroner** **Bedfordshire & Luton**