	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. John Alder, Chief Executive, University Hospitals Leicester
1	**CORONER** I am Catherine Mason, senior coroner/area coroner/assistant coroner, for the coroner area of Leicester City & South Leicestershire
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 2nd April 2013 I commenced an investigation into the death of Gillian Crossley aged 76 years. The investigation concluded at the end of the inquest on 29th August 2014. The conclusion of the inquest was that there were failings in her care and she was discharged home when she should not have been. As a result there was a missed opportunity to detect her deteriorating condition sooner. However, because the mechanism for the insult to the bowel was unknown, it was also unknown if the outcome would have been different.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Crossley underwent elective bowel surgery on the 18th March 2013. The surgery was technically successful but her recovery period was slower than expected and she was discharged home on the 26th March 2013 but re-admitted the following day in extremis as a result of bowel necrosis and subsequent perforation. Despite further surgical intervention she remained gravely ill and died on the 28th March 2013.
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 have received previous assurances from the University Hospitals Leicester that measures have been in place to audit documentation so that it meets professional standards. However, I found the following during this inquiry: (1) Inadequate documentation (2) Failure to observe and monitor in accordance with Mrs Crossley's needs (3) Failure to properly assess the fitness for discharge and properly plan that discharge (4) Inadequate communication between those who were responsible for the care and treatment of Mrs Crossley
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 the 30th October 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] (Son) [redacted] (Daughter) I have also sent it to the 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.
9	**4th September 2014**