Thomas R Osborne
Senior Coroner for Bedfordshire and Luton

	REGULATION 28: REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Stephen Conroy** **Chief Executive** **Bedford Hospital NHS Trust** **Kempston Road** **Bedford** **MK42 9DJ**
1	**CORONER** I am Thomas R Osborne, Senior Coroner for 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/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 10th May 2013 I commenced an Investigation into the death of **Sonielia Laura Caya HOLMES**, aged 23 years . The Investigation concluded at the end of the inquest on 21st October 2014. The Conclusion of the Inquest was a Narrative Conclusion: Sonielia Laura Caya HOLMES was admitted to Bedford Hospital on 17th April 2013 suffering from confusion and seizures; she had a history of tonsillitis for the previous two weeks. She was eventually diagnosed with Haemophagocytic Syndrome on 2nd May 2013 following a fall which, as a result of her blood disorder, caused a bleed in her brain. The brain injury resulted in a lost opportunity to treat her underlying condition and she deteriorated and died from Multi Organ Failure at 17:06 hours on 4th May 2013.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was taken to Bedford Hospital South Wing on 17th April 2013 suffering acute confusion and seizures. She was very unwell and taken to the Critical Care Complex the following day. She had mixed clotting abnormalities

	and was ventilated and treated. She was returned to Ward on 22nd April 2013. She deteriorated again and got out of bed on 2nd May 2013 and fell over. A CT scan revealed extra cranial and intracranial injuries. She was taken back to the Critical Care Complex, ventilated again and had a repeated CT scan. A referral to Addenbrooke's Hospital and The National Centre for Neurology in London was made, but both stated that she was not suitable for further intervention. Her pupils had become fixed and she died whilst still receiving supportive treatment.
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. That on numerous occasions it proved impossible for the doctors attending Miss Holmes to contact the Haematology Department at the Hospital. This was despite the staff using all known contact details, including mobile phones and bleep numbers. 2. That the Haematologists working within the Hospital failed to respond to messages left for them to offer advice and to review Miss Holmes. 3. It was apparent from the evidence that Haematology is a vital service within the Hospital and any failure to respond to requests for assistance from other clinicians will put lives at risk.
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 Bedford Hospital NHS Trust, 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 **11th December 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] **– Mother** 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 23rd October 2014** …… **Thomas R Osborne** **Senior Coroner** **Bedfordshire and Luton**

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