Thomas Ralph Osborne
Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive** Milton Keynes Hospital Standing Way Milton Keynes MK6 5LD
1	**CORONER** I am Thomas Ralph Osborne, Senior Coroner for Milton Keynes
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 09/04/2013 I commenced an investigation into the death of Peter John White aged 79 . The investigation concluded at the end of the inquest on 05 September 2014. The conclusion of the inquest was a Narrative conclusion: Peter John White was involved in a Road Traffic Collision on 2nd April 2013 and suffered serious injuries. He was taken by ambulance to Milton Keynes Hospital where the serious nature of his injuries were not recognised; there was a failure to adequately monitor his condition and a failure to escalate his care for a senior review resulting in a series of lost opportunities to render further medical attention and he died on 3rd April 2013 from Haemothorax. The medical cause of death following a post mortem was 1(a)Haemothorax !(b)Blunt Chest Injuries With Azygos Vein Laceration 2. Hypertension (with Left Ventricular Hypertrophy and Benign Nephrosclerosis)
4	**CIRCUMSTANCES OF THE DEATH** At 1653 02/04/13 the deceased was driving a blue Peugot 106, index [redacted] towards the village of Little Horwood along Warren Road. A Royal Mail delivery van, has turned left out of Bacon House Farm and into the path of the deceased. He was taken Milton Keynes Hospital where X rays showed sternal fractures, rib fractures, right sided pleural effusion. He was taken to the surgical assessment unit overnight and became unwell the following morning and suffered a collapse whilst undergoing a CT scan.
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)Evidence was given to me that observation of patients are conducted throughout the Hospital using an Early Warning Observation Chart. The observations are often recorded by unqualified Health Care Assistants but the recordings should be checked and interpreted by a qualified nurse. A trigger score is given for each set of observations; one trigger should result in a review by a senior nurse and an increase in the frequency of observations, two triggers requires a review by a doctor and three triggers a review by a specialist registrar. The chart is a tool to ensure that there is an escalation of care to an appropriate level. (2) In the case of Mr. White the EWS chart was not completed correctly, triggers were ignored and none of the observations were checked by a qualified member of staff. The evidence of Dr.

	[redacted] an independent expert was "This resulted in lost opportunities to reassess Mr. White and put in place the necessary resuscitative measures. (3) I was also told that there is no regular audit system in place to ensure that the charts are correctly completed, interpreted and acted upon.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Chief Executive 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 01/11/2014. 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 namely the family of the deceased and to have also sent it to [redacted] the Medical and Clinical Director and to the Care Quality Commission and Department of Health 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	Dated 05 September 2014 Signature_____ Senior Coroner for Milton Keynes