REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

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THIS REPORT IS BEING SENT TO: 1 Nottingham University Hospitals NHS Trust ("the Trust") 1 CORONER 1 am Miss Stephanie Haskey, Assistant Coroner, for the Coroner area of Nottinghamshire 2 CORONER'S LEGAL POWERS 1 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 The death of Lydia Corah was subject to an Inquest on 11 th May 2015. 4 CIRCUMSTANCES OF THE DEATH Lydia Corah died at the Trust hospital as a result of Multi Organ Failure caused by Group A Beta Streptococcal Sepsis. 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 there was an error, or series of errors, which led to Mrs Corah undergoing an x ray which had been indicated for a different patient, so causing her to experience delay in assessment and treatment and to receive an unnecessary dose of radiation. 2. That the same error, or series of errors, would have adversely affected the patient for whom the x ray request had been properly intended. 6 ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take s		REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
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8 COPIES and PUBLICATION		
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	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:
	N/A
	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	11 th May 2015 Miss Stephanie Jane Haskey, Assistant Coroner, Nottinghamshire