ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Medical Director of Mid Yorkshire Hospitals NHS Trust**
1	**CORONER** I am DAVID HINCHLIFF, Senior Coroner, for the coroner area of West Yorkshire (Eastern) Area
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 the 17th July 2013 I commenced an investigation into the death of Maurice Camfield, aged 71 years. The investigation concluded at the end of the Inquest on 1st April 2015. The cause of death was 1(a) Septicaemia due to 1(b) Perforated gangrenous cholecystitis and 2) Traumatic brain injury, diabetes mellitus and HIV infection. The conclusion which was a short form was Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** Maurice Camfield's medical history was that of suffering from back pain, type 2 diabetes and chronic obstructive pulmonary disease. On 21st April he was involved in a road traffic collision in Bangkok whilst riding a motor cycle which caused him to suffer a traumatic brain injury. He was repatriated to the United Kingdom on 16th May 2013 whereupon he was admitted to Pinderfields General Hospital, Wakefield. The injuries he had sustained in Bangkok were subdural and subarachnoid haemorrhages, fractured ribs, left obstructive uropathy and hydronephrosis and dilatation with linear skull fracture. He developed post injury agitation and seizure activity and he was transferred to the stroke unit where a new diagnosis of HIV was made. Mr Camfield was deemed ready for rehabilitation and was transferred to Dewsbury District Hospital for stroke rehabilitation where his condition deteriorated. On 27th June 2013 he was transferred to the intensive care unit at Dewsbury Hospital where he developed sepsis. He required blood pressure support and inotropes and he was fed by a nasogastric tube. On 5th July 2013 he was transferred back to Pinderfields General Hospital but became immediately unresponsive on the journey and died in the ambulance.

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. I heard evidence at this Inquest from [redacted] a Consultant in Neurological Rehabilitation who expressed the view that it was important that in Mr Camfield's case that those involved in his care and treatment should do so strictly in accordance with the agreed plan which dictated that he should have one to one nursing care at all times. [redacted] stressed the importance of doing what was in the care plan which did not happen in Mr Camfield's case.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. I therefore request that the Trust's Medical Director ascertain from [redacted] the precise nature of her concerns and then should issue the appropriate directions to all Clinicians and nursing staff about the importance of care being given strictly in accordance an agreed care plan. In order to assist I attach a copy of [redacted] report dated 16th December 2013 and a transcript of the evidence she gave at this Inquest.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th June 2015. 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] Medical Director of Mid Yorkshire Hospitals NHS Trust. 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	**[DATE]** 16th April 2015 **[SIGNED BY CORONER]**