#### 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. Chief Executive Worcestershire Acute Hospitals NHS Trust
- 2.
- 3.

#### 1 CORONER

I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire

## 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 17<sup>th</sup> November 2014 I commenced an investigation into the death of Noel Owen JONES then aged 77 years.

The investigation concluded at the end of the inquest on 16 April 2015.

The conclusion of the inquest was he died as the result of known complication of necessary surgery the medical cause of death being 1(a) Shock, 1(b) haemorrhage from left iliac artery and perforated descending colon following cystectomy, 2, atherosclerosis, inhalation of gastric contents, ischaemic heart disease, cancer of the upper rectum irradiation for testicular cancer.

### 4 CIRCUMSTANCES OF THE DEATH

On 2<sup>nd</sup> October 2014 Mr Jones underwent surgery at the Alexandra hospital. He was later discharged before being admitted on two occasions to the Hereford County Hospital.

It is clear that upon his admission to Hereford on 15<sup>th</sup> November 2014 he was severely unwell and had sustained an internal haemorrhage.

The clinicians at Hereford struggled to have Mr Jones admitted to a variety of hospitals including Worcestershire Royal Hospital.

Ultimately when Mr Jones appeared to be in extremis Worcestershire Royal Hospital agreed to accept him and he was rushed there by ambulance but died shortly after his arrival.

It appears that there was a four hour delay between the first telephone call to Worcestershire Royal asking for him to be admitted and his ultimate acceptance.

# 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 that had Mr Jones been accepted by Worcestershire Royal Hospital earlier he would "on the balance of probability" have survived this episode (2) Evidence was given that there is within Worcestershire Royal Hospital no out of hours service for vascular surgery or interventional radiology (3)
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 by reviewing the out of hours or on-call arrangements for vascular surgery or interventional radiology in the case of critically ill patients who needs to be transferred in from elsewhere.
7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 <sup>th</sup> 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 (next of kin)
	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	Signed
	92 Jan
	G U Williams 22nd day of April 2015 H M Senior Coroner
	A CONTRACTOR OF THE CONTRACTOR