



P S Cooper
Her Majesty's Acting Senior Coroner for South Lincolnshire

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. [REDACTED] Legal Services Manager, United Lincolnshire Hospitals NHS Trust, Robey House, Lincoln County Hospital, Greetwell Road, Lincoln, LN2 5QY</p>
1	<p>CORONER</p> <p>I am P.S. Cooper, HM Acting Senior Coroner for the Coroner's area of South Lincolnshire.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 12/06/2015 I commenced an investigation into the death of Sidney Brian Alexander, age 73. The investigation concluded at the end of the inquest on 01/06/2016. The conclusion of the inquest was a Narrative Conclusion (attached)</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Alexander was admitted at 06.30hrs on 19/05/2015 with a background of 1997 cardiac transplant (on immunosuppressants), COPD and colitis. He presented with a few months history of diarrhoea. Treated medically for Crohn's exacerbation with IV steroids and then infliximab to no effect. He developed respiratory distress on 03/06/2015. X-Ray showed diffuse right sided infiltrates. CMV positive Treated with Memperom and Ganciclovir but Mr Alexander died at 2310hrs in the Pilgrim Hospital, Fishtoft.</p>



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5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>1. [REDACTED] Consultant Gastroenterologist gave live evidence, During that evidence he conceded that he hadn't been able to fully complete a Biopsy report for Unilabs as there was insufficient room on it. Surely a form can be expanded or provision made for an addendum?</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th September 2016, I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <p>1. [REDACTED] Legal Services Manager, United Lincolnshire Hospitals NHS Trust, Robey House, Lincoln County Hospital, Greetwell Road, Lincoln, LN2 5QY</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>



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9	Date 18 th July 2016 Paul S Cooper..... <i>Paul S Cooper</i> H M Acting Senior Coroner for South Lincolnshire