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:** **Maidstone and Tunbridge Wells NHS Trust**
1	**CORONER** I am Roger L Hatch senior coroner, for the coroner area of Kent (North-West) District
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 26th October 2012 I commenced an investigation into the death of Frances Olwyn Cappuccini The investigation concluded at the end of the inquest on 16th January 2017 The conclusion of the inquest was that the death of Frances Olwyn Cappuccini was as a result of the failures, inadequate diagnosis and treatment of her at the Tunbridge Wells Hospital on the 9th October 2102 The cause of death was: 1 (a) Cardio-Respiratory Arrest 1 (b) Problems relating to general anaesthesia 1 (c) Recent third trimester delivery Sepsis and Acute Kidney Injury
4	**CIRCUMSTANCES OF THE DEATH** The deceased died on the 9th October 2012 at the Tunbridge Wells Hospital following the birth of her child
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. What action is taken to check and ensure no part of the placenta remains following a caesarean section delivery? 2. The protocol for the management of post partum haemorrhage was not followed by the medical staff. What procedures have been instigated to avoid this happening again.

	3. Supervision – What action has been taken to ensure that staff grade anaesthetists are supervised and that both the staff grade and supervisor are provided details of the respective identities of the parties involved. 4. What steps have been taken to avoid there being delays in a request for urgent help for an intensivist/anaesthetist. 5. The Inquest showed a number of examples of inadequate note keeping at the hospital – what actions have been taken to ensure this is not repeated in the future.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24 March 2017. 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] 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]** 27:1:2017 **[SIGNED BY CORONER]**