IAN SINGLETON
Assistant Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms Nerissa Vaughan Chief Executive Great Western Hospitals NHS Foundation Trust Great Western Hospital Marlborough Road Swindon SN3 6BB [redacted] Patient Safety Domain NHS England Skipton House, Area 6C 80 London Road London SE1 6LH
1	**CORONER** I am IAN SINGLETON, Assistant Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17 September 2015 an investigation was commenced into the death of Christina Bernadette Withey aged 70. The investigation concluded at the end of the Inquest with a Jury on 31 March 2017, having heard evidence on 28, 29, 30 and 31 March 2017. The conclusion of the Inquest was one of a narrative.
4	**CIRCUMSTANCES OF THE DEATH** Christina was an inpatient at Great Western Hospital, having been admitted on the 10 September 2015, with abdominal pain, constipation and pyrexia. At some point either late on the 14 September or during the 15 September 2015 Christina suffered a stercoral perforation leading to faecal peritonitis, sepsis and multi organ failure which caused her death on the afternoon of 15 September 2015.
5	**CORONER'S CONCERNS** During the course of the inquest which was conducted with a Jury, evidence was heard from a number of witnesses who had been involved with Mrs Withey's care and or the subsequent investigation carried out by the Hospital. It was accepted by the Hospital that in a number of respects the level of care provided to Mrs Withey had not been as high as it might have been. Although the Jury found that those matters did

not contribute to her death they did give rise to a 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) The keeping of patient records in relation to a urine chart and the accurate measuring of output.

(2) The period before a review of a patient is carried out where there has been no improvement in condition.

(3) Review of the sepsis guidelines in the light of the "Acute care toolkit 9: sepsis" produced by The Royal College of Physicians

(4) The training of locums and other temporary staff

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 02 June 2017. I, the Assistant 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]
DAC Beachcroft LLP
Portwall Place
Portwall Lane
Bristol
BS1 9HS

[redacted]
S J Edney Solicitors
Alexander House
19 Fleming Way
Swindon
SN1 2NG

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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9 Dated 07 April 2017

Signature _____
Assistant Coroner for Wiltshire and Swindon