Crispin Giles Butler
Senior Coroner for Buckinghamshire

<table>
<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:
1. The Chief Executive, Fremantle Trust
2. The Head of Clinical Services, Fremantle Trust</td></tr>
<tr><td>1</td><td>CORONER

I am Crispin Giles Butler, Senior Coroner for Buckinghamshire</td></tr>
<tr><td>2</td><td>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</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On 20th May 2016 I commenced an investigation into the death of Helen Yuk Ying BANNISTER, born on the 8th January 1947. The investigation concluded at the end of the inquest on 27th September 2017. The conclusion of the inquest was as follows:

Medical cause of death:
1a. Sepsis
1b. Bronchopneumonia and peritonitis
1c. Recent surgery to insert a gastronomy feeding tube (PEG)

The narrative conclusion recorded:
On 13th May 2016, Helen Bannister underwent a procedure at Stoke Mandeville Hospital, Buckinghamshire to insert a gastronomy feeding tube (PEG). The loosening of the PEG occurred at some time after discharge from Stoke Mandeville Hospital and led to a leak into her abdomen which caused the infection from which Helen Bannister died.</td></tr>
<tr><td>4</td><td>CIRCUMSTANCES OF THE DEATH
Helen Bannister was a resident at Lent Rise House, part of the Fremantle Trust.
Her ability to swallow and take food and drink orally had been becoming compromised and it was agreed she would undergo a procedure as a day patient at Stoke Mandeville Hospital so that she could be fed in future with a PEG feeding regime whilst retaining the ability to take some soft food or liquids orally.
The narrative conclusion (above) sets out the brief facts.
After discharge from Stoke Mandeville Hospital, Helen Bannister returned to Lent Rise. At some time during this short period she became ill and this was subsequently identified by Wexham Park Hospital and at post mortem to be due to a leak into her abdomen leading to infection. She had received emergency treatment, a washout and removal of the PEG at Wexham Park shortly before her death.
Section 3 of the Record of Inquest recorded that Helen Bannister died at 0415hrs on 17th May at Wexham Park Hospital, Berkshire as a result of sepsis.</td></tr>
<tr><td>5</td><td><u>CORONER'S CONCERNS</u>

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows. –</td></tr>
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The Coroner's Court, 29 Windsor End, Beaconsfield, Buckinghamshire, HP9 2JJ
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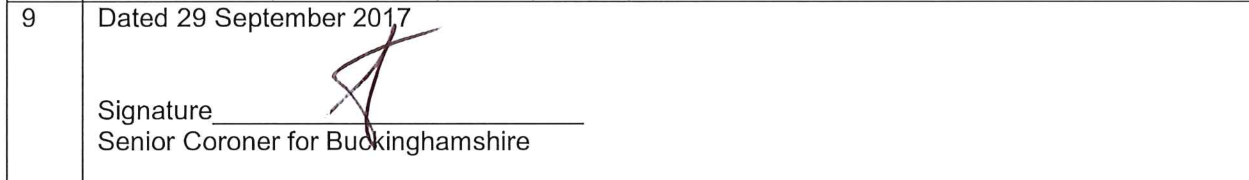
	There was, understandably, a significant volume of documents and records from Lent Rise used to record the various elements of the care Helen Bannister received whilst at Lent Rise. During the course of the investigation and in evidence at the inquest, whilst there was an indication that procedures, documentation and staff awareness has been under review since the death of Helen Bannister, there remains a significant concern that the keeping of accurate records in respect of all aspects of care, fluid intake, diet and nutrition and the proper recording of hospital discharge arrangements and aftercare instructions needs to be improved. There remains a continuing risk that the ability of care workers, nurses, doctors and hospitals to react properly to unfolding events may be compromised by incomplete records intended to accurately document all actions taken and the relevant timings of those actions in the care of a resident.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Fremantle Trust 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 November 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: The Bannister family Buckinghamshire Healthcare NHS Trust Frimley Health NHS Foundation 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	Dated 29 September 2017  Signature____________________________ Senior Coroner for Buckinghamshire

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