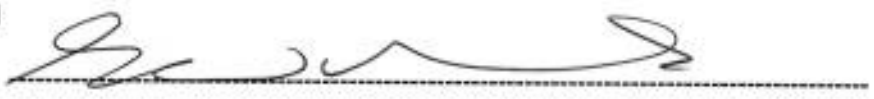
ANNEX A

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 Hospital 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 20th July 2017 I commenced an investigation into the death of Michael Edward Giles then aged 78 years. The investigation concluded at the end of the inquest on 25th October 2017. The conclusion of the inquest was Mr Giles died as the result of a known complication of the surgical procedure. The medical cause of death being 1(a) acute haemorrhage from the liver, 1(b) liver biopsy, 2 chronic myeloid leukaemia, adenocarcinoma of the sigmoid colon, malignant melanoma of the right eye lid, .
4	**CIRCUMSTANCES OF THE DEATH** Mr Giles became unwell and was admitted into hospital and following a diagnostic surgical procedure he declined and died
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. – The Hospital Trust's internal report revealed a number of matters of concern in respect of which this report is written. (1) The handover process between shifts was expressed to be different throughout the hospital on different wards. This potentially leads to inconsistency with inadequate information being shared. It was not clear whose responsibility it was to ensure that the handover was undertaken in full and thorough fashion. The highlighting of the needs of particular patients who were the subject of the

	handover was inadequate. I invite the Trust to consider standardising the handover process across the hospital and to put in place a protocol whereby the identity of the person responsible for ensuring the handover takes place is clearly recognised (2) The absence of a senior review of patients over the weekend was a factor in the suboptimal care given to this patient. I invite the Trust to put in place a requirement that all complex cases who are admitted into the ward on Friday or over the weekend, particularly where they have undergone invasive procedures, are routinely subject to a senior doctor review. (3) There was an acknowledgement within the Trusts investigation that, during the crisis period of this patient's admission there was a lack of leadership from both clinicians and nurses with no one taking responsibility to ensure that tests and investigations were in fact carried out and followed up. I invite the trust to consider a protocol to ensure that in such situations there is a nominated individual to take the lead and to ensure optimum care is given. 4 The case notes and medical records were (again) inadequate. I have been told on many occasions that the importance of good record-keeping is emphasised to clinicians - sadly in this case yet again the lessons do not appear to be being learned. I invite the Trust to put in place additional training so that record-keeping is consistent, complete and clear.
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 25th December 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	**Signed**  **G U Williams** **30th day of October 2017** **H M Senior Coroner**