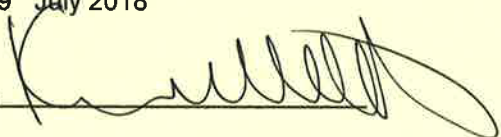




H M Senior Coroner for Gloucestershire  
Ms Katy Skerrett

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b> <b>Chief Executive Ms A Young, North Bristol NHS Trust, Southmead Hospital. Southmead road, Bristol BS10 5NB</b></p>
1	<p><b>CORONER</b></p> <p>I am Katy Skerrett, Senior Coroner for Gloucestershire.</p>
2	<p><b>CORONER'S LEGAL POWERS</b></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><b>INVESTIGATION and INQUEST</b></p> <p>On the 22<sup>nd</sup> May 2017 I commenced an investigation into the death of Robert Andrew Power. The investigation concluded at the end of the inquest on the 4<sup>th</sup> May 2018. The conclusion of the inquest was natural causes. The medical cause of death was 1A Bronchopneumonia and urinary tract infection, 1B Multiple Sclerosis.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Robert Andrew Power "Robert" was a 49 year old man who lived in a care home specialising in neurological conditions. He had a history of significant drug and alcohol abuse. In 2007 he suffered a marked change in his physical abilities, and he underwent extensive investigations. He was diagnosed with gliomatosis cerebri, and discharged to a terminal care home. This diagnosis was incorrect. In 2014 his GP requested further assessment of Robert. Neurological opinion was sought, and it was determined that Robert had suffered significant damage to his brain, and had a chronic undefined inflammatory condition affecting his brain. In July 2015 Robert was admitted to a care home specialising in neurological management. Thereafter whilst Robert's condition remained relatively stable, he was admitted to hospital on multiple occasions suffering with aspiration pneumonia, and / or seizure activity. Following ongoing deterioration, and after discussion with his family, it was agreed there would be no further escalation of treatment in the event of further deterioration. On the 12<sup>th</sup> April 2017 Robert was admitted to hospital suffering with aspiration pneumonia. He was discharged on the 4<sup>th</sup> May 2017 for palliative care. His condition steadily deteriorated. He was regularly reviewed by his GP. Robert passed away on the 17<sup>th</sup> May 2017.</p>
5	<p>During the course of the inquest the evidence revealed a matter giving rise to concern.</p> <p>The <b>MATTER OF CONCERN</b> was as follows. – Robert whilst being treated as a patient by the trust was essentially lost to follow up between 2007 – 2015. No explanation was given as to why this happened.</p> <p>For the reasons given in my summary of evidence I determined that there was no evidence that this area of concern had any direct causative impact on Robert's death. However in my opinion there is a risk that future deaths may occur unless action is taken to ensure that outpatients are not lost to follow up care. It is acknowledged that significant steps have already been made.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p>

	<p>I acknowledge receipt of your submissions dated 18<sup>th</sup> May 2018. You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm 27<sup>th</sup> August 2018 <b>if</b> there are any additional submissions that have not already been made, 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><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <ul style="list-style-type: none"><li>(1) [REDACTED]</li><li>(2) Chief Executive Mr Jones, Ramsay Health Care, Level 18, Tower 42, 25 Old Broad Street, London EC2N 1HQ</li></ul> <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>
9	<p>Dated 9<sup>th</sup> July 2018</p> <p>Signature </p> <p>Ms K Skerrett Senior Coroner for Gloucestershire</p>