Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:
Mr Joe Harrison, Chief Executive, Milton Keynes University Hospital

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

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 13th June 2019 I commenced an investigation into the death of John SHROSBREE aged 72. The investigation concluded at the end of the inquest on 25th September 2019.

The conclusion of the inquest was a narrative conclusion:

> *The deceased was admitted to Milton Keynes University Hospital on 4th June 2019 clearly unwell, there was a failure to recognise the serious nature of his condition and a failure to take the necessary steps to treat it. He went into cardiac arrest and suffered hypoxicbrain injury and died on 11th June 2019.*

4 CIRCUMSTANCES OF THE DEATH

The deceased was admitted by his GP via ambulance to Milton Keynes University Hospital on the 4th June 2019 very unwell. His observations and tests confirmed he was unwell with a high potassium level, his observations were not reviewed, his care was not escalated to a higher level, he was transferred to a non-observable and unmonitored bay in the emergency department, there was a delay in starting treatment to reverse his condition and he was transferred for a CT scan when unstable. He suffered hypoxic brain damage following a hyperkalaemic cardiac arrest and died on 11th June 2019

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:
My concern is that during the evidence it became clear that that the problems encountered in the Emergency Department on 4th June 2019 were mainly brought about by staff shortages. I was told that staff shortages occur on a daily basis and I believe that as a result lives of this citizens of Milton Keynes are being put at risk and the problem should be addressed as a matter of urgency.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 21st November 2019. 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 Family of Mr Shrosbree
The Care Quality Commission

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

Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 26 September 2019