ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Kettering General Hospital NHS Foundation Trust**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Northamptonshire
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 8 January 2019 I commenced an investigation into the death of Susan Sterland, age 76. The investigation concluded at the end of the inquest on 23 January 2020. The conclusion of the inquest was that Susan Sterland died of undiagnosed intestinal obstruction.
4	**CIRCUMSTANCES OF THE DEATH** Susan Sterland was brought by ambulance to the emergency department of Kettering General Hospital on 29th December 2018. She had intestinal obstruction which was not diagnosed. Ms Sterland was diagnosed with constipation and admitted to the emergency decisions unit (EDU). The intention was to admit her to the medical ward but there were no available beds and so she remained on EDU for two nights. During the time she was in hospital she was seen by two experienced Advanced Care Practitioners (ACP) and by one junior doctor (FY1). She was never seen by senior doctor. During the day on 30 December she showed some signs of deterioration. Her condition then rapidly deteriorated during the late evening of 30 December 2018 but her care was not escalated. She collapsed and died early on 31 December 2018.
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. – This was obviously a very busy time at the hospital. However, Ms Sterland was in the hospital for some 40 hours, she was not getting better, there were signs that she was deteriorating during the late morning and afternoon of 30 December, there was a plan to admit her to a ward but there were no beds available. My concern is that in this situation she was not seen by a senior doctor. If Ms Sterland had been seen by a senior doctor the evidence was that she would have had further investigation which would have led to earlier diagnosis of the obstruction and may have altered the outcome.

	The evidence at the inquest suggested that there are some categories of patients in the emergency department for whom a senior review is mandatory. It may be that the Trust would wish to consider whether the circumstances of this case suggest that there are other situations in which a senior review should be required.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **26 March 2020**. 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 Ms Sterland's family as Interested Persons. 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	**28 January 2020** **Philip Barlow**