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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Medical Director** **United Lincolnshire Hospital Trust**
1.	**CORONER** I am Paul Cooper, Assistant Coroner for the coroner area of Lincolnshire, 4 Lindum Road, Lincoln, Lincolnshire, LN2 1NN.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3.	**INVESTIGATION and INQUEST** On 09/10/2019 I commenced an investigation into the death of Vilmantas Venskutonis, aged 30. The investigation concluded at the end of the inquest on 07/04/2021. The conclusion of the inquest was that Vilmantas Venskutonis died as a result of Natural causes, the medical cause of death being: 1a. Acute Myocardial Infarction 1b. Thrombosis and Occlusion of the Left Anterior Descending Branch of the Coronary Artery 1c. 2.
4.	**CIRCUMSTANCES OF THE DEATH** 1.Admitted to Pilgrim Hospital with chest pains 2.Chest pains intensified 3.Transfererred to Lincoln County Hospital 4.11 separate intervention opportunities acknowledged that were missed at the Pilgrim 5. Died in County Hospital
5.	**<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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

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	The **MATTERS OF CONCERN** are as follows. – I refer to the action plan dated December 2019 that was attached to the SI report, Lead Investigator, Dr [redacted] (Cardiology). The commencement of the plan is January 2020. There are nine points to this plan, I need to know if the plan has been implemented in full to prevent further deaths with implementation dates for all 9 points. If not implemented in full or in part please state reason why identifying each point.
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 16/06/2021. 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 (a) NOK 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.
	Date: «AuthorisedDateShort» «AuthorisingUserSignature» «AuthorisingUserFullName» «AuthorisingUserAppointment» P.S. Cooper 21/4/21.