##DW<<ALLTRIM(cSignedBy)>>
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##DW<<ALLTRIM(cJurisdiction)>>

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **University Hospitals Plymouth NHS Trust**
1	**CORONER** I am Ian Arrow, Senior Coroner for Plymouth Torbay and South Devon
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** Following an Inquest opened on the 19 December 2017 and an inquest hearing at HM Coroner's Court, Plymouth on the 7 June 2021 heard before Ian Michael Arrow, in the coroner's area for Plymouth, Torbay and South Devon.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from significant comorbidities in particular ischaemic heart disease. She was determined by her GP to be suffering from Anaemia. She was admitted to hospital for a blood transfusion whilst in hospital, hospital clinicians determined an endoscopy was an appropriate procedure to investigate blood loss. This endoscopy investigation was carried out on 11th of December 2017. The endoscopy investigation was abandoned. On the balance of probability there was a perforation of the oesophagus during the procedure. The deceased developed symptoms of surgical emphysema. She deteriorated and died on 11th of December 2017 at Derriford Hospital, Plymouth. NARRATIVE
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) There appears to be a significant discrepancy between clinicians on the consenting procedure for the identical treatment of endoscopy. (2) A 'sip test' to exclude aspiration was not performed, and there has been no evidence that this had been noted or remedied at the Trust. (3) A doctor did not take action when viewing an endoscopy report which contained an indication of a possible dangerous complication. (4) Appropriate records were not kept, or were not properly transferred, by senior staff.

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. Please review the matters of concern in para 5 above.
	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 16 August 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 Ms Woodfield's family. I have also sent it to Derriford Hospital who may find it useful or of interest. 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	Dated 21.06.2021 Signature