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: Joe Harrison CEO, Milton Keynes 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 07/08/2019 I commenced an investigation into the death of Thomas Henry SMYTH aged 86. The investigation concluded at the end of the inquest on 17 October 2019. The conclusion of the inquest was a narrative conclusion as follows;
The deceased was admitted to Milton Keynes University Hospital on 12th July 2019 following a fall at his nursing home. A CT scan revealed a subdural haematoma and the neurosurgeons advised that his anticoagulation medication should be stopped. It was inappropriately restarted on 13th July 2019 and this resulted in his clinical deterioration and he died from the subdural haematoma on 3rd August 2019 at Mallard House Milton Keynes.

4 CIRCUMSTANCES OF THE DEATH
See narrative conclusion.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:
During the course of the evidence I heard from consultants and more junior staff that they were unaware of certain facts relating to Mr. Smyth at the time that they were dealing with him and making decisions relating to his care, and yet the information was recorded in the electronic notes and records.
It appears to me that staff are having difficulty accessing vital information that should be clearly available to them. I would ask that you carry out a review of the notes system to see whether or not it is being used correctly, whether staff members have been adequately trained with regard to its use and whether changes should be made as to how information is recorded and retrieved. Unless the system is working effectively I anticipate that further lives will be put at risk.

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 December 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 Smyth
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: 28 October 2019