A R W Forrest LLM, FRCP, FRCPath
GMC Number: 1333523
Her Majesty's Senior Coroner for South Lincolnshire

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ms Jane Lewington, Chief Executive, United Lincolnshire Hospitals**
1	**CORONER** I am ARW Forrest, senior coroner for the coroner area of South Lincolnshire.
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 2nd November 2012 I commenced an investigation into the death of Jessica Florence Ashton-Pyatt, Age 14. The investigation concluded at the end of the inquest on 30th August 2013. The conclusion of the inquest was spontaneous rupture of the stomach of uncertain cause; verdict was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** On 28th October 2012 Jessica became acutely unwell. On admission to the Accident and Emergency Unit at Pilgrim Hospital she was *in extremis*. Resuscitation attempts were unsuccessful. Post mortem showed her cause of death to be a ruptured stomach of uncertain, but natural cause.
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. – The response of the staff to Jessica's care on admission was unco-ordinated, with the immediate care being delivered by an SpR in anaesthetics and two EMAS paramedics. There was initially no consultant leadership of Jessica's care. The defibrillator in the resuscitation bay was not charged and no defibrillation pads were initially available.
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.

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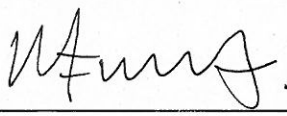
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th October 2013. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise 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 [redacted] and [redacted] and to the Local Safeguarding Board for Lincolnshire and Staffordshire (where the deceased was under 18)]. I have also sent it to [redacted], Risk Manager, United Lincolnshire Hospitals and [redacted], Nurse Consultant, Accident and Emergency Unit, Pilgrim 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	**30/08/2013 ARW Forrest (HM Senior Coroner for South Lincolnshire)** 

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[redacted]