REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT is being sent to: **Ms Pauline PHILIP** **Chief Executive** **L & D University Hospital** **Lewsey Road** **Luton** **LU4 4DZ**
1	**CORONER** I am **Mr Tom OSBORNE,** Senior Coroner for the Coroner Area of Bedfordshire and Luton.
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**
3	**INVESTIGATION and INQUEST** On the 19th June 2013 I commenced an Investigation into the death of **Aimee Sarah VARNEY** aged 21 years. The Investigation concluded at the end of the Inquest on 19th May 2014. The Conclusion of the Inquest was that between January 2012 and April 2013 the deceased was undergoing investigation for epilepsy at the Luton & Dunstable Hospital. She died following a seizure on 16th June 2014 at her home address [redacted] Dunstable, Bedfordshire. The medical cause of death being: I (a) Sudden Unexpected Death in Epilepsy
4	**CIRCUMSTANCES OF THE DEATH** **Aimee Sarah VARNEY** had undergone investigations for epilepsy between January 2012 and April 2013. She was seen at the Luton & Dunstable Hospital on 22nd April 2013 following which a referral was made for her to be seen by a Specialist at the Royal Free Hospital in London.

	The failure to refer her urgently, or at all, to a Specialised Unit resulted in a lost opportunity to diagnose and further treat her condition. She died following a seizure from Sudden Unexpected Death in Epilepsy on 16th June 2013 at 22 Priory Heights, Dunstable, Bedfordshire.
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: 1. That the NICE Guidelines for referring a patient with suspected epilepsy to a Specialist Tertiary Centre were not followed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of the Luton & Dunstable University Hospital, 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 **28th July 2014**; 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 Person(s): **The family** 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 this 2nd day of June 2014** **.....** **Tom OSBORNE** **Senior Coroner** **Bedfordshire & Luton**