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. Mr John Adler, Chief Executive, University Hospitals of Leicester NHS Trust**
1	**CORONER** I am Lydia Brown assistant coroner, for the coroner area of Leicester (City and South)
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 24 May 2013 I commenced an investigation into the death of Janet Doreen Goodacre, age 88. The investigation concluded at the end of the inquest on 10th September 2014. The cause of death was: 1a Acute Gastrointestinal bleed, 1b. Combination of antiplatelet and anticoagulation therapy, 1c. Atrial Fibrillation and acute coronary syndrome, 2. Myocardial infarction: Congestive cardiac failure. The conclusion of the inquest was a narrative conclusion : Mrs Goodacre was admitted to Leicester Royal Infirmary on 1st May 2013 and she remained an in-patient until her death on 21st May 2013. During her stay she developed atrial fibrillation and was started on warfarin, and continued on other medications including deltaparin and aspirin. On the balance of probabilities this combination of medication provoked and then exacerbated a gastro intestinal bleed which led to her death. This was a recognised complication of her necessary medical treatment.
4	**CIRCUMSTANCES OF THE DEATH** See Narrative Conclusion above
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. The **MATTERS OF CONCERN** are as follows. – University Hospitals of Leicester NHS Trust ("the Trust") prepared an Investigation report concerning this death, and this was signed off on 15th January 2014. A copy was duly provided to the Coroner's office in accordance with the local approved information sharing agreement. On the day of the inquest itself, nearly 9 months later, without any amendments or further communications from the Trust, Evidence was heard that (1) the Trust acknowledged that the report was factually incorrect

	(2) That the only 2 “Root causes” identified in the report were incorrect (3) the Clinical Lead (who signed off the Investigation Report) said it was “flawed” and “not helpful” I am therefore concerned that the Trust is providing inaccurate and misleading investigation reports, and Action Plans based on the erroneous findings that are not only of no assistance, but in fact divert attention away from the actual difficulties in service provision that should be identified. This not only fails to achieve the intention of the investigation, but also has the potential to miss opportunities to prevent future deaths. Furthermore, there was a failure to communicate the Trust knowledge of the Investigation Reports shortcomings until the day of the Inquest itself, and it was clear no attempts had been made to revisit the report to correct the recognized errors. I request to be advised of any actions that have been taken to improve and oversee the preparation and conclusions of Investigation Reports, and that consideration be given to introduce a system to re-open any reports found to be inadequate or erroneous.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 6th November 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 Persons: [redacted] (Daughter Of Mrs Goodacre) I have also sent it to [redacted] Medical Director NHS England 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	**18 September 2014**