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HM Senior Coroner for Essex

ANNEX A

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:** **Southend Hospital**
1	**CORONER** I am Caroline Beasley-Murray, Senior Coroner, for the coroner area of Essex
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 18 April 2012 Dr Peter Dean the former Southend Coroner commenced an investigation into the death of Frances Margaret Ann Bell. The investigation concluded by me at the end of the inquest on 6 March 2014. The conclusion of the inquest was a narrative verdict:- In the evening of 30 March 2012, Frances Margaret Ann Bell presented at Southend Hospital and she was discharged just after midnight. She was readmitted the next day and on 1 April she underwent abdominal surgery. She died on 13 April 2012. There were very serious failings in the care Mrs Bell received in Southend Hospital. With timely, appropriate care Mrs Bell might have survived. The medical cause of death was :- 1a) bowel ischaemia b) internal herniation 11) abdominal adhesions
4	**CIRCUMSTANCES OF THE DEATH**

	On 30 March 2012 Mrs Bell presented at Southend Hospital with abdominal pain and she was discharged at just after midnight On 31 March Mrs Bell was readmitted and she underwent surgery on 1 April There were very serious failings in the care Mrs Bell received in Southend Hospital
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) There was no Root Causes Analysis Investigation carried out which would have identified lessons learned and an action plan (2) There was no input from senior clinical staff at the time of Mrs Bell's presentation on 30 March (3) There was an unacceptable delay between Mrs Bell's readmission on the 31 March and her arrival in theatre on 1 April
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 1st August 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 – Pattinson Brewer solicitor acting on behalf of the family 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	**6 June 2014**