	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:**
1	**CORONER** I am Margaret Joy Jones, Assistant Coroner, for Stoke-on-Trent & North Staffordshire.
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/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 05/09/2014 I commenced an investigation into the death of Benjamin John William Bartle aged 71 years. The investigation concluded at the end of the inquest on 18th June 2015. The conclusion of the inquest was that the deceased died from a recognised complication of surgery. The deceased was admitted to the University Hospital North Staffordshire, Stoke on Trent on the 6th August 2014 and underwent elective laparoscopic resection of his colon for early colon cancer. Post operatively he had problems with small bowel obstruction requiring a further laparotomy and release of adhesions. He had a pre-sacral collection drained on the 22nd August 2014. He developed an infection which did not respond to intravenous antibiotic treatment and suffered an acute cardiac event. He died at 4.30 pm on the 26th August 2014. The cause of death was septicaemia due to laparoscopic anterior resection for early colon cancer.
4	**CIRCUMSTANCES OF THE DEATH** See above.
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. The family perceived a lack of staff over the Bank Holiday weekend, Friday 22nd August to Monday 25th August which they felt led to delayed interventions for Mr Bartle. 2. The family perception was of poor nutritional support and pain control for Mr Bartle. 3. The family experienced poor communication from nursing staff.

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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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday14th August 2015. 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:- 1. [redacted] 2. [redacted] 3. [redacted] (daughter) 4. 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 18 June 2015 Signature [redacted] for Stoke-on-Trent & North Staffordshire

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