H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive, Trust Headquarters, Gloucestershire Hospitals NHS Foundation Trust, 1 College Lawn, Cheltenham, Gloucestershire GL53 7AG [redacted] Head of Legal Services, Legal Services Department, Cheltenham General Hospital, Sandford Road, Cheltenham, Gloucestershire GL53 7AN
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 the 21st June 2013 the Acting Coroner for Gloucestershire commenced an investigation into the death of Samantha Beach. The inquest was formally opened on the 25th June 2013, and I held a pre inquest review on the 26th June 2014 (having been appointed as Senior Coroner for Gloucestershire on the 1st June 2014). The investigation concluded at the end of the inquest on the 8th-9th October 2015. The conclusion of the inquest was a narrative conclusion. The medical cause of death was ruptured splenic artery aneurysm.
4	**CIRCUMSTANCES OF THE DEATH** Sam was a healthy 25 year old young lady. She had given birth to two babies previously without any problems. On the 10th June 2013 she developed severe chest pain within three hours of giving birth to her third child. She also developed intermittent tachycardia. Her pain persisted when she was discharged from hospital on the 12th June 2013. Whilst she was in hospital her severe chest pain was not investigated appropriately. Sam made midwives and junior doctors aware of her pain. Advice was not sought from more senior colleagues. Between the 13th – 15th June her chest pain continued and she was seen at home by community midwives and an out of hours GP. Sam was not readmitted to hospital. On the 17th June she attended the emergency department with ongoing chest pain, but she was discharged again within three hours. Advice from an obstetrician was not sought. On the 20th June 2013 she had further severe chest pain, she fitted and then she collapsed. Whilst she was being transferred to hospital she had a cardiac arrest. She was admitted to hospital in a state of cardiac arrest. Cardio-pulmonary resuscitation was carried out. The clinicians considered the most likely diagnosis to be pulmonary embolism, and therefore Sam was anticoagulated. However it soon became apparent that her abdomen was swelling, and intra-abdominal bleeding was suspected. An emergency laparotomy was carried out, and it was found that she had bleeding from a ruptured splenic artery aneurysm. A splenectomy was carried out. Postoperatively her condition deteriorated. The clinicians could not stabilize her coagulation. She suffered a further cardiac arrest on the morning of the 21st June 2013. She was pronounced deceased at 06.58 hours. If her severe chest pain had been adequately investigated it is more probable than not that her splenic artery aneurysm would have been detected. If detected, it is more probable than not that Sam could have undergone successful operative repair.

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 clinical care provided to Sam in the obstetric department was not escalated appropriately to more senior colleagues, (2) When Sam was being cared for in the community, there was no process to ensure the sharing of information or joining up of care between the midwives, out of hours, GP and obstetric department. (3) When Sam attended the Emergency Department as a post-natal patient (7 days post partum) the obstetric department were not involved in her care.
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 4pm 17th December 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], Iacopi-Palmer Solicitors (solicitors for [redacted] partner of Sam), Spinnaker House, Spinnaker Road, Gloucester GL2 5FD (2) [redacted], mother of Sam, [redacted] 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 21st October 2015 Signature_____ Ms K Skerrett Senior Coroner for Gloucestershire