	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Medical Director, Ipswich Hospital.**
1	**CORONER** I am Dr Peter Dean, senior coroner for the coroner area of Suffolk
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 8th of April 2015, I resumed the inquest into the death of FIONA MARGARET PATRICIA LEWIS. The conclusion at the end of inquest was that the death was due to Natural Causes, however there were circumstances in respect of this very sad death that gave rise to concern.
4	**CIRCUMSTANCES OF THE DEATH** Fiona Luis was admitted to Ipswich Hospital on the 5th of September 2014 following a three week period of symptoms which had initially suggested a possible orthopaedic problem, although there was then concern that there was an underlying neurological component to her condition. There were clearly difficulties in obtaining a clinical diagnosis for the condition in life, which were looked into at the inquest given her son's concerns here, but her condition sadly deteriorated and she passed away at Ipswich Hospital on the 13th of September 2014. By that time an underlying malignancy was suspected but not proven, and the cause of death was found by an independent pathologist to be from Disseminated Carcinoma. No primary mass could be identified at post mortem examination. Medical management and diagnostic issues were explored at the inquest, as stated above. There were, however, concerns raised after the death by one of the nursing staff that health care professionals working on the ward had failed to initiate prompt resuscitation following the collapse, despite Fiona Luis still being for resuscitation in the event of a collapse occurring, and that, once the problem was recognised, appropriate knowledge or ability in respect of resuscitation was not displayed by those health care professionals. These matters were explored at the inquest, but there was evidence that it was unlikely that failure of prompt resuscitation would have altered the outcome here in view of CSF involvement by tumour.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Although, in the very sad circumstances of the death of Fiona Luis, any problems in respect of resuscitation at the time of the collapse are unlikely to have affected the outcome for the reasons given above, it is clearly important that there is confidence that health care professionals involved with patient care are adequately trained in resuscitation and able to respond appropriately in the event of a collapse occurring.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe those responsible for the health care professionals at the hospital have the power to take such action. While there was clearly evidence that there was resuscitation training in place within the hospital, what was more difficult was assessing how effective that training had been. In order to minimise the risk of resuscitation associated problems compromising the chances of a successful outcome following a collapse, I would ask that the way in which resuscitation training is provided within the hospital be reviewed and consideration be given as to how the effectiveness of that training can be assessed and audited.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 12th of November 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: The family of Fiona Luis Similarly, you are 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.
9	**Dr Peter Dean 17-9-15**