REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive of the Doncaster and Bassetlaw Hospitals NHS Foundation Trust (the Trust)**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 1st December 2014, I commenced an investigation into the death of Douglas Kay, aged 90 years. The investigation concluded at the end of the inquest on 14th August 2015. The conclusion of the inquest was one of Natural Causes
4	**CIRCUMSTANCES OF THE DEATH** Mr Kay was an elderly man, but was reasonably fit for his age. He presented to Bassetlaw Hospital with bleeding from a duodenal ulcer on 16th November 2014. He was admitted, monitored and given medication to try and heal the ulcer. On the evening of the 22nd November, Mr Kay became suddenly unwell with clear evidence of active bleeding from the ulcer, with a blood stained vomit and black stools. This was a catastrophic bleed and despite attempts to resuscitate him, he died approximately 7 hours later. Throughout the period of his deterioration there was significant confusion about the arrangements for a possible transfer to Doncaster Hospital for further treatment. The Trust completed an Investigation report, produced an action plan, and submitted further reports during the Inquest. All these documents went some way to addressing concerns raised in evidence, however, in my view there remain outstanding concerns that allow for the continuation of circumstances creating a risk that other deaths will occur if such matters are not addressed.
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. – • There remain significant confusion, and uncertainty about how, and when, to transfer a patient with gastrointestinal bleeding, with no clear agreed policy or procedure available within the Trust • There are new arrangements for the provision of a gastrointestinal bleeding service at Doncaster Hospital, but key Senior staff at Bassetlaw Hospital are not aware of how it operates, particularly out of hours.
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 the 11th April 2016. 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] son and next of kin 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	**5th February 2016** **Dr E A Didcock**