Thomas R Osborne
Senior Coroner for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Mr Stephen Conroy** **Chief Executive** **Bedford Hospital NHS Trust** **Kempston Road** **Bedford** **MK42 9DJ**
1	**CORONER** I am Thomas R Osborne, Senior Coroner for Bedfordshire and Luton
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 14 August 2015 I commenced an Investigation into the death of **David MOSTARI**, aged 70 years. The Investigation concluded at the end of the Inquest on 13 January 2016. The Conclusion of the Inquest was a 'Narrative Conclusion' that: "…The deceased was admitted to Bedford Hospital on 8 August 2015 at 11:03 hours. He was seriously unwell and there was a failure to recognise the serious nature of his condition and a failure to take the necessary steps to treat him appropriately. This resulted in a lost opportunity to intervene earlier and he died on 10 August 2015 from peritonitis following a perforated bowel".
4	**CIRCUMSTANCES of the DEATH** The Deceased was admitted to Bedford Hospital South Wing at 11.03 hours on 8 August 2015 with a history of suggested flare up of his ulcerative colitis. He was managed on a Ward until he deteriorated in the early hours of 10 August 2015. He was then taken to the Critical Care Complex and subsequently into theatre where a laparotomy was performed. A perforated colon with widespread faecal contamination was found, and a partial colectomy

	performed. On return from theatre he remained moribund but further resuscitation allowed commencement of haemofiltration. Unfortunately he continued to deteriorate and later that evening it was apparent that treatment was futile and hence, with the agreement of the family, withdrawn.
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. Mr. Mostari was admitted to the Hospital on a Saturday and despite the need for an urgent x-ray and ultra sound scan the tests were not in fact carried out until the Monday. There therefore does not appear to be any robust system in place for ensuring that urgent tests and imaging are carried out without delay, particularly when a patient is admitted at the week-end. The deceased needed the tests and follow up treatment as a matter of urgency.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as the Chief Executive 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 **2nd 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 Person(s) The family via son – [redacted] I have also sent it to: The Care Quality Commission (via e-mail) who may find it useful or of interest

	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 5th February 2016** ……. **TOM OSBORNE** **Senior Coroner** **Bedfordshire and Luton**