REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) Mr Simon Stevens, Chief Executive, NHS England** **2) Mr John Adler, Chief Executive, University Hospitals of Leicester NHS Trust (UHL)**
1	**CORONER** I am Mrs Dianne Hocking Assistant Coroner, for the area of Leicester City and Leicestershire South
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 22 June 2016 I commenced an investigation into the death of Margaret Mary Dempsie. The Inquest concluded on 24 October 2016 Cause of death: 1a Septicaemia 1b Bilateral Pyelonephritis (Proteus bacteria) 2 Dementia and frailty of old age. Coroners Conclusion: Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Dempsie had lived in a residential care home where she had District Nurses and her General Practitioner visit her to give treatment for infected leg ulcers for more than one year. Her past medical history included advanced dementia, hypertension and arthritis. She was eventually admitted to the Leicester Royal Infirmary on the 04 April 2016 for treatment of her leg ulcers and she was recovering and awaiting a package of care for her discharge when she suddenly deteriorated and it was apparent that she was, once again, suffering from sepsis. There was nothing more than could be done and Mrs Dempsie was discharged for end of life care to a nursing home and she died there 2 days later. She was under a Deprivation of Liberty Safeguarding Order at the time of her death.
5	**CORONER'S CONCERNS** The discharge letter from the University Hospitals of Leicester NHS Trust addressed to the primary care team contained inaccuracies. It stated that Mrs Dempsie had been suffering from aspiration pneumonia when no pneumonia had been identified and did not mention pyelonephritis, which had been present. The Consultant who was looking after Mrs Dempsie was not surprised and admitted in the inquest that the Discharge

	Letters for patients were being completed with mistakes by the Junior Doctors, that this was something that happens and that GP's regularly have to phone the hospital to ascertain the correct facts. He said that sometimes the junior doctors who complete the discharge letters have never seen the patient. This situation was also confirmed by the General Practitioner who was also present at the inquest. I have concerns that the wrong information is being passed on to primary carers who are then, of course, obliged to act upon the information they are furnished with in the Discharge Letter and that this could lead to serious mistakes being made in the care of vulnerable patients newly discharged from hospital.
I.	**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 Monday 19th December 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) 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	**[DATE]** **[SIGNED BY CORONER]** **24/10/2016**