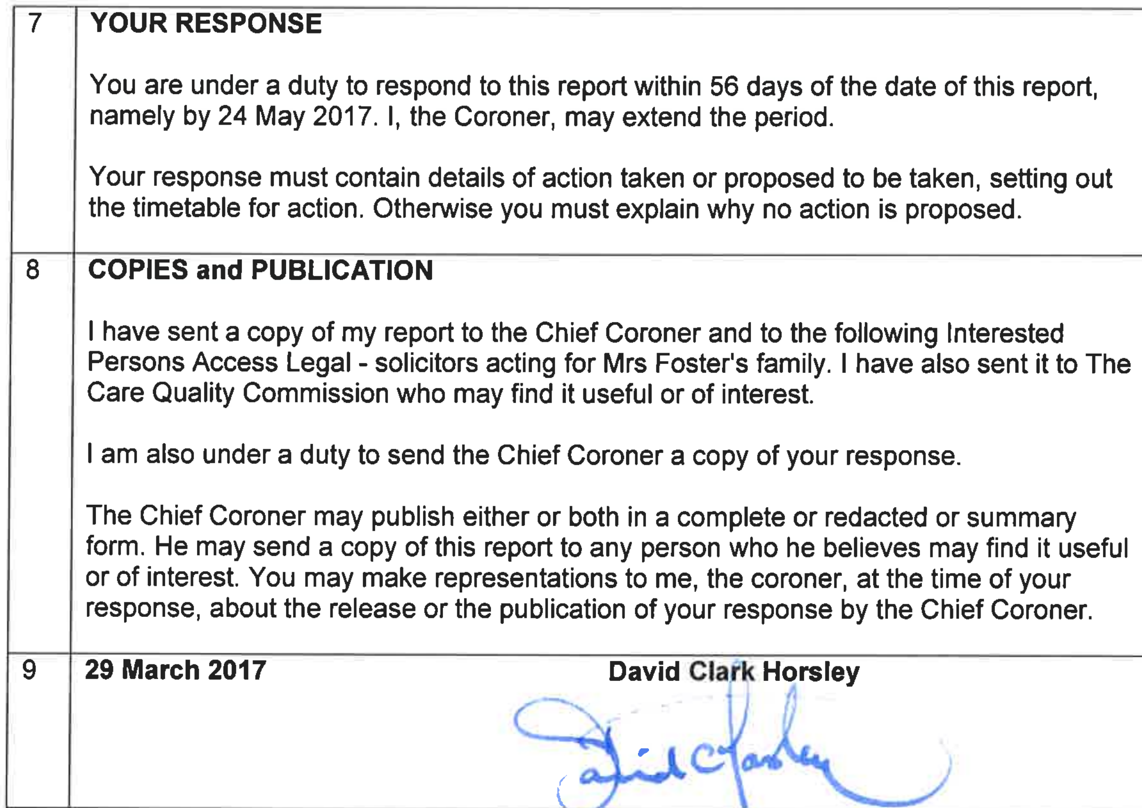
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr T Powell, Chief Executive, Portsmouth Hospitals NHS Trust**
1	**CORONER** I am David Clark Horsley, H.M. Senior Coroner for the Coroner area of Portsmouth and South East Hampshire.
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 7 June 2016 I commenced an investigation into the death of Beryl Yvonne Foster, aged 76. The investigation concluded at the end of the inquest on 14 March 2017. The conclusion of the inquest was a Narrative Conclusion (which is attached hereto). The medical cause of Mrs Foster's death was: 1(a). Respiratory Failure 1(b). Pneumonia 1(c). Oesophageal Perforation 2. Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** Mrs Foster underwent an endoscopic ultrasound examination at Queen Alexandra Hospital on 8 December 2015. She became unwell after discharge from the hospital and was re-admitted on 11 December 2015 and subsequently died there on 2 January 2016.
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. – Mrs Foster's discharge summary was handed to her on 8 December 2015 and was subsequently posted to her GP practice. This meant that when she became unwell the following day and contacted the practice, it was unaware of the endoscopy the previous day. I was told that endoscopy discharge summaries are posted to GP practices by QAH, rather than emailed like all other discharge summaries. I am concerned this practice raises a risk that future deaths will occur in such circumstances and I would ask the NHS Trust to consider emailing all discharge summaries to GP practices in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 24 May 2017. 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 Access Legal - solicitors acting for Mrs Foster's family. I have also sent it to The Care Quality Commission 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	**29 March 2017** **David Clark Horsley**