	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, Royal Stoke University Hospital, Stoke-on-Trent
1	**CORONER** I am Emma Serrano Area Coroner for **Stoke-on-Trent & North Staffordshire Coroner's Court**
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 30/03/2021 I commenced an investigation into the death of Diana Iris Joan Reay, aged 79. The investigation concluded at the end of the inquest on 31st August 2021. The conclusion of the inquest was Diana Iris Joan Reay passed away on the 11 March 2021 at the Royal Stoke University Hospital, Stoke-on-Trent from an acute kidney injury. This was caused by sepsis and community acquired pneumonia. The Medical Cause of death was found to be: 1a) Acute kidney injury. 1b) Sepsis. 1c) Community acquired pneumonia. II) Fascioscapulohumeral dystrophy
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are that Diana Reay was transferred from the County Hospital to the Royal Stoke University Hospital, Stoke-on-Trent on the 17 February 2021. Whilst she was being treated in hospital she was diagnosed with community acquired pneumonia. This led to sepsis and an acute kidney injury. She passed away on the 11 March 2021.
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) Numerous doctors failed to interpret the scans that Diana Reay had correctly. It was accepted that they were wrongly interpreted so that a fluid filled cyst was mistaken for a full bladder. This resulted in numerous re-catheterisations of Mrs Reay when this was un-necessary.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 12th November 2021. 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: 1. The family of Diana Reay. I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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	15/09/2021 Signature  Emma Serrano Area Coroner **Stoke-on-Trent & North Staffordshire Coroner's Court**