	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Barnsley District General Hospital, Gawber Road, Barnsley, S75 2EP** **2. Kendray Hospital, Kendray Hospital Lodge, Doncaster Road, Barnsley, S70 3RD**
1	**CORONER** I am David Urpeth, Senior Coroner, for the Coroner Area of South Yorkshire West
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 13.7.21, an investigation into the death of Ann Pickering was commenced. The investigation concluded at the end of the inquest on 24.6.22. The conclusion of the inquest was a narrative conclusion, copy attached.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Pickering began complaining of throat swelling and a sense of choking. Various tests found no issues with her throat or swallowing function. She refused to eat and drink sufficient and was diagnosed with severe anxiety and an eating disorder. She was admitted to Kendray hospital and placed under a s2 MHA order. Following a decline in her physical health she was transferred to Barnsley Hospital where she remained until her death on 1.7.21. The evidence was that there was a delay in recognising the need for an NG tube and actually inserting one. The evidence was that the delay did not cause her death.
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. – During the inquest, evidence showed:- 1. There was a recognition on 17.2.21 by Kendray Hospital that NG tube feeding was required. 2. Barnsley Hospital did not initially feel transfer should take place to them and it was not until 23.6.21 that they accepted a transfer 3. Despite recognising an NG tube was required, one was not inserted until the 30.6.21 4. There was a lack of clear policies and procedure about how a patient under a section should be transferred and what documentation / resource should go with them.

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 29.8.22. 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 to all Interested Persons :- Family Barnsley District General Hospital Kendray Hospital 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: 4.7.22**  **SIGNED BY** **DAVID URPETH, SENIOR CORONER SOUTH YORKSHIRE (WEST)**