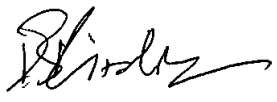
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted] Chief Executive Royal Stoke University Hospital**
1	**CORONER** I am Duncan Ritchie, Assistant Coroner for the coroner area of Stoke-on-Trent and North Staffordshire
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 10 March 2022 I commenced an investigation into the death of Sara Anest JONES aged 25. The investigation concluded at the end of the inquest on 07 March 2023. The conclusion of the inquest was that: Sara Anest Jones died at the Royal Stoke University Hospital, Stoke-on-Trent on 2nd April 2021 of complications of a bowel injury sustained in a road traffic collision on 30th March 2021. Miss Jones was treated for her injuries at the Royal Stoke University Hospital, Stoke-on-Trent. Those responsible for Miss Jones' care at the Royal Stoke University Hospital did not identify that she had sustained a bowel injury and consequently it remained untreated. Miss Jones developed peritonitis because of the untreated bowel injury, from which she later died.
4	**CIRCUMSTANCES OF THE DEATH** Road traffic collision contributed to by neglect
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) The patient was admitted to Royal Stoke University Hospital, Stoke-on-Trent as a "polytrauma" patient who had sustained serious injuries in a road traffic collision. Following her admission, she was treated by doctors from several different specialisms, but it was apparent that some doctors involved in her care concentrated on only the injuries which fell within their specialty and did not consider the patient as a whole. At an important stage in her treatment the general surgeons thought that the orthopaedic surgeons would alert them to any intervention which was needed from their specialty, whilst the orthopaedic surgeons expected the general surgeons to regularly review the patient.

	Partly as a result of doctors concentrating only on the injuries which fell within their specialty signs of a bowel injury which the patient had sustained were missed. The patient subsequently died as a result of complications of the undiagnosed bowel injury. Evidence was given during the inquest that a major trauma consultant role was in the process of being developed at the Royal Stoke University Hospital, Stoke-on-Trent to address issues like this, but that the role was only 50% filled at the current time.
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 May 09, 2023. 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 Sara Jones. 2. [redacted], Head of Legal Services at Betsi Cadwaladr University Health Board I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any 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 by the Chief Coroner.
9	**Dated: 15th March 2023**  **Signed:** **Duncan Ritchie** **Assistant Coroner for Stoke-on-Trent and North Staffordshire**