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 Milton Keynes University Hospital**
1	**CORONER** I am Tom OSBORNE, Senior Coroner for the coroner area of Milton Keynes
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 03 April 2023 I commenced an investigation into the death of Harry Arthur STOBIE aged 77. The investigation concluded at the end of the inquest on 20 July 2023. The conclusion of the inquest was that: Narrative Conclusion - Died as a result of a haemoperitoneum after insertion of a PEG tube, that is a recognised complication of a necessary medical procedure.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered a stroke on 15th February 2023 and was admitted to Milton Keynes University hospital and transferred to John Radcliffe hospital for a thrombectomy and was repatriated back to Milton Keynes on the 20th February 2023, he underwent a PEG insertion on the 23rd March 2023 caused a large haemoperitoneum that was not recognised at the time. His condition deteriorated and he died on 26th March 2023.
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) That once the PEG tube was inserted at Milton Keynes Hospital it seems that the deceased's deteriorating condition was not monitored closely even though he was complaining of abdominal pain soon after the procedure was completed . His concerns were not escalated to a senior doctor for consideration of a possible bleed. The procedures and protocols following PEG insertions should be reviewed.
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 September 29, 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 [redacted] I have also sent it to [redacted] who may find it useful or of interest. 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: 04/08/2023**  **Tom OSBORNE** **Senior Coroner for** **Milton Keynes**