REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. County Hospital Stafford;** **2. Chief Coroner; and** **3. Family of the deceased.**
1	**CORONER** I am Emma Serrano, Acting Senior Coroner of 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 the 17th April 2023 2023, I commenced an investigation into the death of Mrs Hart. The investigation concluded at the end of the inquest on 16 October 2024. The conclusion of the inquest was a conclusion of natural causes. The cause of death was: 1a) Sepsis, 1b) Acute Limb Ischaemia 1c) Peripheral vascular disease II) Diabetes mellitus
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Hart was admitted to the County Hospital in Stafford on the 19 March 2023. On the 21 Marc 2023 she started to show signs of having a ischaemic leg. On the 27th march vascular specialist review was requested. There is no vascular team located on the County Hospital, so the review was delayed for 4 days untill the Vascular Consultant was next at the County Hospital. ii) At the review, the decision was made that Mrs Hart was for palliative care only. She passed away on the 8 April 2023
5	**<u>CORONER'S CONCERNS</u>** 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. There is no vascular team in hand at the County Hospital in Stafford, were urgent Vascular opinion required.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 5 December 2024. 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 County Hospital in Staffordshire and the family of Phyllis Christina Hart. 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	**16 February 2024**  **Miss Emma Serrano** **Acting Senior Coroner** **Staffordshire sss**

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