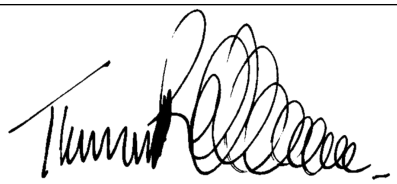
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted] – CEO 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 21 January 2025 I commenced an investigation into the death of Karl Fraser DUNSTAN aged 56. The investigation concluded at the end of the inquest on 23 June 2025. The conclusion of the inquest was that: Narrative conclusion The deceased died at Milton Keynes University Hospital on 14th January 2025 from a pulmonary embolism arising from a deep vein thrombosis. The opportunity to investigate and treat the pulmonary embolism was missed when the request for a CT pulmonary angiogram was declined without D-dimer testing and, when his clinical condition declined, was not met with emergency treatment for a pulmonary embolism. The missed opportunities more than minimally contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** Karl Dunstan died at Milton Keynes University Hospital on 14th January 2025 from a pulmonary thromboembolism arising from a deep vein thrombosis. He had been admitted to the hospital the previous day with symptoms suggestive of a chest infection, but also with clinical features indicative of a pulmonary embolism, including shortage of breath, episodes of collapse and hypoxia. A request for a CT pulmonary angiogram was denied by the radiologist as it did not meet their criteria. There was a failure to perform a D-dimer test that if positive would have led to a CTPA that would have confirmed the pulmonary embolism. This would have resulted in thrombolysis being started when he collapsed.
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: That the investigation of a pulmonary embolism was not carried out in accordance with NICE guidance, and a request for a CT pulmonary angiogram by the consultant was rejected by the radiology department because it did not meet the threshold of the Wells score used by the Hospital and yet a D-dimer test was not completed, that if positive, would have resulted in a CTPA. The policy and procedure is in need of an urgent review.
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 August 18, 2025. 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 **The family of Mr Dunstan** 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: 24/06/2025**

	 **Tom OSBORNE** **Senior Coroner for** **Milton Keynes**