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** **2 Bedford General Hospital** **3 Luton and Dunstable Hospital** **4 Stoke Mandeville 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 26 April 2025 I commenced an investigation into the death of Suzanne EDWARDS aged 71. The investigation concluded at the end of the inquest on 24 July 2025. The conclusion of the inquest was that: Narrative conclusion The deceased died at Bedford General Hospital on 1st December 2024 from sepsis arising from an infected and obstructed kidney. in the 48 hours before her death, she consulted her GP and was later assessed at Milton Keynes University Hospital. While appropriate individual steps were taken at each contact, there was a failure to recognise signs of a urinary tract obstruction resulting in a lost opportunity to treat the condition before the sepsis developed.
4	**CIRCUMSTANCES OF THE DEATH** The deceased became very unwell on the 29th November 2024, she was seen by her GP and assessed at Milton Keynes Hospital, she was admitted to Bedford Hospital and underwent surgery to insert a stent in her kidney, she became increasingly unwell and died of sepsis at Bedford Hospital on 1st December 2024.
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: Emergency Departments at hospitals in this and surrounding jurisdictions do not have reliable access to patients' primary care records, including recent GP consultations, investigations or concerns. This means that clinicians are frequently treating acutely unwell patients without full access to their recent medical history, which can delay or misdirect diagnosis and undermine patient safety and continuity of care and lead to avoidable deaths.

	Without access to a patients full records further lives may be put at risk.
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 26th 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 **Family of Mrs Edwards** 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: 01/08/2025**  **Tom OSBORNE** **Senior Coroner for** **Milton Keynes**