The Office of Tom Osborne
Her Majesty's Senior Coroner for Milton Keynes

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Chief Executive
NHS England
Hertfordshire and South Midlands Area
Charter House
Parkway
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Hertfordshire
AL8 6JL

28th November

Dear Sir/Madam,

Re: Regulation 28 Report to Prevent Future Deaths

I, as the Senior Coroner for the Coroner Area of Milton Keynes, 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.

On 8th July 2013, I commenced an investigation into the death of Doris Phoebe Miller. The investigation concluded at the end of the inquest on 26th November 2013. The conclusion of the inquest was that Mrs Miller had died from natural causes.

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) Mrs Miller's notes and records were unavailable to the GP surgery at Broughton Gate despite having been transferred to the surgery, following the closure of the Willen practice in April 2013. Indeed I was informed by a GP who gave evidence before me that she was still, in November 2013, unable to access the patient records. Over 2000 patients were transferred to Broughton Gate and if the circumstance above continues there is a possibility that lives will be put at risk.

(2) On the 23rd July 2013 the GP had requested the district nurses to attend Mrs Miller to carry out an urgent blood test. The GP was dismayed to discover a week later that the blood sample had not been taken and that the results, therefore, were not available to her. There appears to be no system for effective communication between the GP surgery and the district nurses. Again this gives rise to a concern that lives may be at risk.

(3) During the inquest hearing it became apparent that the surgery at Broughton Gate did not have access to a pulse oximeter to measure Mrs Miller's oxygenation. This is a relatively inexpensive item and should perhaps be available in every doctor's surgery throughout the country.

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

You are under a duty to respond to this report within 56 days of the date of this report, namely by January 23rd 2014. I, the coroner, may extend the period.

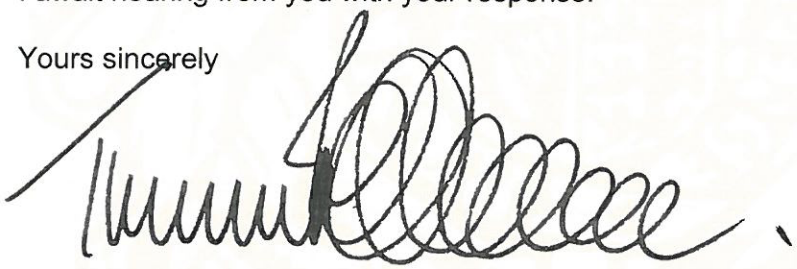
Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. I have sent a copy of my report to the Chief Coroner and to the family as properly Interested Persons. I have also sent a copy to Care Quality Commission who may find it useful or of interest.

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.

I await hearing from you with your response.

Yours sincerely



Tom Osborne
Her Majesty's Senior Coroner for Milton Keynes

This report is being sent to:

- **Family of Doris Miller**
- **Chief Coroner**
- **Care Quality Commission**
- **The Practice**
- [redacted]