REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Stockport NHS Foundation Trust**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 10th July 2014 I commenced an investigation into the death of Neil Thomas Westerman dob 20th June 1942. The investigation concluded on the 5th January 2015 and the conclusion was one of **misadventure**. The medical cause of death was 1a Multi system organ failure 1b Septicaemia 1c Biliary leak following laparoscopic abdominal surgery.
4	**CIRCUMSTANCES OF THE DEATH** **On the 2nd July 2014 he attended Stepping Hill Hospital for an elective cholecystectomy. The operation led to a leakage of bile causing septicaemia.**
5	**CORONER'S CONCERNS** 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. During the course of the inquest I heard evidence that the pre-operative assessment was performed by a junior doctor and not by the consultant who was to perform the procedure. This meant that the consultant was unaware of certain vital information.** **2. The operation notes did not contain details of the equipment and materials used during the procedure and it was agreed that this should be the case and that all such items should be fully recorded and accounted for at the conclusion of the procedure.** **3. I heard evidence, as I have on previous occasions, that there were simply too few junior doctors on duty to cover the needs of the patients, especially at night. It was not suggested that the numbers were not in compliance with the set guidelines, but rather that in practice there simply weren't enough doctors available.**

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 6th May 2015. 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 namely [redacted] **(widow of the deceased)**. I have also sent it to the **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.
9	**11.3.15** [redacted] **John Pollard, HM Senior Coroner**