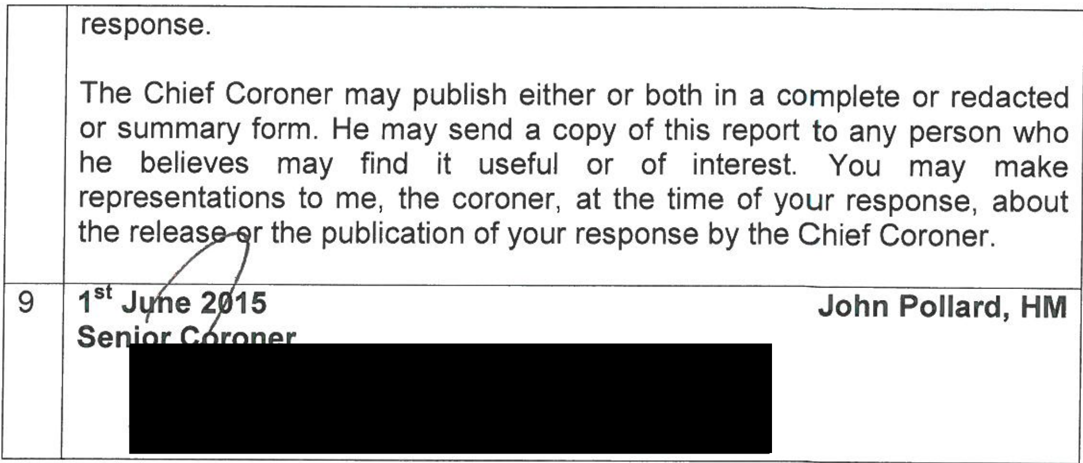
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: THE SECRETARY OF STATE FOR HEALTH; AND THE CHIEF EXECUTIVE OFFICER, UNIVERSITY HOSPITAL OF SOUTH MANCHESTER.**
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 8TH January 2015 I commenced an investigation into the death of **David Glyn Price** dob 2nd October 1959. The investigation concluded on the 1st June 2015 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a Previous myocardial infarction, treated by coronary artery bypass graft and mitral valve disease treated by valve replacement 11. Steato-hepatitis: peri-cardial abscess**
4	**CIRCUMSTANCES OF THE DEATH** **In early June 2011 he suffered a heart attack and was operated on at Wythenshawe Hospital. In the course of the operative procedures, a swab was inadvertently left inside his body attached to his heart. This gradually formed an abscess.**
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.Before he was admitted to hospital his G.P. was prescribing warfarin and this continued over many months despite the fact that he failed on three occasions to attend the anti- coagulation clinic. There is apparently no system to prevent this happening. I have noted in many inquests that people who have "repeat prescriptions" continue to get all the drugs prescribed even if they are no longer needed or wanted, thus potentially placing the patient at considerable health risk but also costing the NHS a vast amount of money for unwanted and unused drugs.(For the Secretary of State) **2. The quality of the handwritten notes (both medical and nursing) was nothing short of very poor. They were frequently undated, unsigned and there was no indication in block letters as to who was completing the notes, his/her professional status etc.(For UHSM)** **3. Even though a "specialist radiologist" looked at the X-Rays, and noted that they appeared to show a foreign body within the thorax of the patient, this was not read or seen by any of the treating doctors, or if it was seen it was not in any way acted upon. (This was of course an image of the rogue swab which was left in the body.) (UHSM)** **4. There did not seem to be in place any, or any satisfactory, swab count policy, such that none of the nurses during any of the three heart procedures, noticed that there was a discrepancy.(UHSM)**
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 those parts of this report which relate to your organisation, within 56 days of the date of this report, namely by **27th July 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 **CQC** 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	**1st June 2015** **John Pollard, HM Senior Coroner**