REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Secretary of State for Health
1	**CORONER** I am M Jennifer Leeming, Senior Coroner, for the Coroner Area of Manchester West
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 31st December 2014 I commenced an investigation into the death of Margaret Elaine Wright, 72 years. The investigation concluded at the end of the inquest on 7th May 2015. The conclusion of the inquest was that Margaret Elaine Wright died of a complication of surgery for hepatocellular carcinoma which carcinoma was itself a complication of previous blood transfusions.
4	**CIRCUMSTANCES OF THE DEATH** Between the 7th January 1969 and the 21st January 1969 Margaret Elaine Wright was transfused 11 units of blood at Bury General Hospital. In 2012 she was diagnosed to have hepatitis C and to have developed liver cirrhosis. In 2014 she was diagnosed to have developed hepatocellular carcinoma. These were consequent upon the aforementioned blood transfusions having been contaminated. On the 7th of November 2014 she underwent surgery for hepatocellular carcinoma at the Manchester Royal Infirmary. She was discharged from that hospital on the 11th December 2014. Thereafter her condition gradually deteriorated until on the 17th of December 2014 her husband contacted his Doctor's practice and requested a home visit. The Doctor doing home visits on that day was unaware of Mrs Wright's recent surgery since the practice had not received a discharge summary from the hospital. The Doctor therefore visited other patients during the afternoon of the 17th of December, which meant that he had insufficient time to visit Mrs Wright until the evening. Before the Doctor arrived Mrs Wright collapsed. An ambulance was called and she was admitted to hospital, where she died on the 23rd December 2014.

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)The Doctors did not at that time telephone patients or their families when a home visit had been requested to obtain further information about the patient's situation. Had that happened in this case Mrs Wright would have received a priority visit, although there was no evidence that this would have affected the outcome. Evidence was given that since Mrs Wright's death a system of a Doctor telephoning patients or their families prior to visiting had been introduced, both in the Doctors practice in question and in the local area. Evidence was given that this best practice should be drawn to the attention of the Secretary of State for Health in order to prevent future deaths.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 6th 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 [redacted] I have also sent it to Dr [redacted] 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	**Dated** **11th May 2015**	**Signed** **M Jennifer Leeming**