REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, BMI Healthcare Ltd., The Alexandra Hospital, Mill Lane, Cheadle, Cheshire SK8 2PX**
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 13th February 2015 I commenced an investigation into the death of **Barbara Joan Harrison** dob 28th August 1944. The investigation concluded on the 13th July 2015 and the conclusion was one of **Misadventure**. The medical cause of death was 1a Mediastinitis
4	**CIRCUMSTANCES OF THE DEATH** **In late January 2015 Mrs Harrison had a scan of her neck as she had been experiencing worsening symptoms of difficulty swallowing and regurgitation. Surgery by way of stapling had earlier been attempted at the Regency hospital in Macclesfield, but this proved unsuccessful and she was referred to [redacted] at the Alexandra Hospital, where she was admitted on the 5th February and operated upon that day. Post operatively she developed significant surgical emphysema and an undetected mediastinitis.**
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. **After the first surgery at the Alexandra Hospital she was subjected to physiotherapy involving blowing hard into a peak flow meter. This undoubtedly either caused or contributed to the breakdown of the tissues around the operative site. It is unclear as to who ordered this physiotherapy, as [redacted] the surgeon and [redacted] the anaesthetist both indicated that they did not do so and would not have done so.** 2. **During surgery to repair the oesophageal pouch, there were a total of three attempts to site an endo-tracheal tube and on each occasion it failed. Part of the reason for this was that it was found that the batteries for the fibre optic tube were flat and inoperable. No replacement could be found.** 3. **[redacted] averred that "we never got a light source at all" during the operation. This is an unacceptable situation during a critical operative**

	procedure. He then went on to say " The need for an endoscope was critical and this is now a panic situation with the possibility of something going catastrophically wrong" **4. Whilst the patient was in theatre for the emergency procedure, her family were advised to wait in the restaurant or reception areas of the hospital. As they were waiting, they heard one of the porters shout out "we have got a cardiac arrest in theatre." This caused them extreme distress and alarm."** **5. After the first surgery had taken place, the family noticed there was a rapid and very obvious swelling around the neck and face of Mrs Harrison. Why did the nurses not note this and act upon it earlier?**
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 **8th September 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] **(husband of the deceased)**. I have also sent it to **C.Q.C**. 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	**13.7.15** [redacted] **John Pollard, HM Senior Coroner**