REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Maidstone & Tunbridge Wells NHS Trust**
1	**CORONER** I am Patricia Harding, senior coroner, for the coroner area of Mid Kent & Medway
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 6th March 2015 I commenced an investigation into the death of Christine McNamara. The investigation concluded at the end of the inquest on 11th November 2015. The conclusion of the inquest was that Christine McNamara died on 27th February 2015 at Maidstone Hospital as a consequence of a complication of an elective retrograde cholangiopancreatography (sepsis following a lower bile duct perforation).
4	**CIRCUMSTANCES OF THE DEATH** Christine McNamara was admitted to Maidstone Hospital on 25th February 2015 for an ERCP. Approximately 2 hours after the procedure a doctor noted symptoms suggestive of a bowel perforation. She was managed conservatively. A CT scan conducted 10 ½ hours later confirmed a perforation. When her condition deteriorated on the evening of the 26th February she underwent a laparotomy which did not identify the perforation, but a washout and gastro-jejunostomy were performed. She deteriorated further and died. I have provided my findings to the Trust concerned in writing
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) It was established during the inquest that here was no pathway or guideline in place for post ERCP patients who develop complications (2)Out of hours radiography can only be referred on a consultant to consultant basis. There is no surgical consultant on call from Maidstone during the working week although there is a surgical consultant at Tunbridge Wells
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 11th January 2016. 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 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	**[DATE]** 16th November 2015 **[SIGNED BY CORONER]** P Hawley