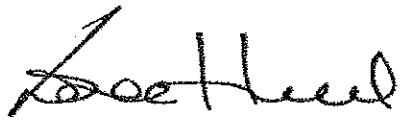
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] **2. The Practice manager at Central Surgery**
1	**CORONER** I am Louise Hunt Senior Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 25/06/2015 I commenced an investigation into the death of Michael Patrick Joseph LOGUE. The investigation concluded at the end of the inquest 2nd November 2015. The conclusion of the inquest was that the deceased died from recognised complications following a liver transplant.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a liver transplant on 03/07/12. He developed a biliary stricture after the operation. He was admitted for biliary reconstruction surgery on 29/05/15. He went home on 01/06/15. He requested a home visit from his GP as he was complaining of pain on 03/06/15. The GP did not carry out a physical examination. He requested a further home visit by another GP on 09/06/15 who carried out a physical examination and diagnosed a wound infection. He was admitted to University Hospital Coventry and Warwickshire on 11/06/15 where he died a few hours later. A post mortem examination confirmed that he died from sepsis from a liver abscess following the biliary tree reconstruction.
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 GP failed to carry out any physical examination of the patient during a home visit on 03/06/15. Mr Logue was complaining of not feeling at all well and of pain and was 5 days post biliary reconstruction surgery.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 30th December 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 The family and NHS England. 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	04/11/2015  Louise Hunt Senior Coroner **Birmingham & Solihull District**