REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Mrs Diane Whittingham, Chief Executive, University Hospital South Manchester NHS Foundation Trust Southmoor Road Wythenshawe Manchester M23 9LT
1	**CORONER** Andrew Bridgman, Assistant Coroner, for the coroner area of Manchester South.
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 26th February 2016 an investigation was commenced into the death of Patrick Curran who died at Trafford General Hospital on 22nd February 2016. The investigation concluded with an Inquest held on 13th July 2016. :Medical cause of death Ia Pneumonia Ib Asbestosis, Chronic Obstructive Pulmonary Disease, and Adenocarcinoma of the lung (treated surgically) Ic Smoking and asbestos exposure II Coronary artery atheroma Conclusion: Industrial Disease
4	**CIRCUMSTANCES OF THE DEATH** In December 2015 Mr Curran was diagnosed with Stage 1B lung cancer (T2a N0 M0) as determined by PET scan carried out at the Manchester Royal Infirmary. Mr Curran was referred to [redacted] Consultant in Thoracic Surgery. On 5th January 2016 Mr Curran underwent resection of the upper right lobe, and mediastinal lymph nodes. Following surgery and histology the tumour was re-staged as a Stage 3A (T3 N2 M0) poorly differentiated adenocarcinoma. Mr Curran was discharged on the 4th post-operative day, 9th January 2016. He was discharged with a chest drain in situ. With regard to the chest drain Mr Curran was reviewed in a 'nurse-led' clinic on 18th January, 25th January and 29th January. At the last appointment the chest drain was removed. At none of these appointments was Mr Curran seen by a doctor. Mr Curran attended for his first post-discharge review on 12th February. He was seen by

	a Senior Specialist Nurse in Thoracic Surgery. It was noted that Mr Curran, - looked a bit frail - was struggling to recover post-operatively - was low in mood - had poor appetite and had lost weight, and that his family were encouraging him to have Fortisips between meals in an attempt to regain weight In his statement [redacted] refers to the fact it was obvious, at that clinic, that Mr Curran would not be able to tolerate adjuvant chemotherapy. That could only be based on the Sister's assessment. [redacted] accepted that such a presentation would not be the norm for a 4-weeks post discharge review. A chest xray was taken. [redacted] stated in evidence that he reviewed this xray. In his evidence he said there were no obvious suggestions of an ongoing chest infection. I have not seen the radiologist's report of that xray. I do not therefore know whether that statement is correct either in so far as it related to obvious signs and in addition whether more subtle changes were present. Although [redacted] was asked to review the xray by the Sister he was not asked to see Mr Curran. [redacted] accepted in evidence that he ought to have been asked to see Mr Curran, and a fortiori he would have done. Mr Curran was discharged by the Sister back to [redacted]. [redacted] advised that it would likely be 3-4 weeks before Mr Curran was seen. [redacted] was not immediately aware that Mr Curran had been discharged and that he had not seen him post-op. An attempt was made to contact Mr Curran on 22nd February. Mr Curran was admitted to Trafford General Hospital on 17th February. He was very unwell. The impression was of a pneumonia that had *"been developing for a period of weeks"*. It was treated, given the history of recent admission for surgery, as a hospital acquired pneumonia and IV Tazocin administered. Treatment was unfortunately not successful and Mr Curran passed away in the early hours of 22nd February.
5	**CORONER'S CONCERNS** It is highly likely that Mr Curran had a pneumonia on 12th February, hence his presentation as described by the Specialist Sister. It is possible that the pneumonia was present at the chest drain reviews. It causes me great concern that a patient who must have been presenting as unwell and not as expected at a 4 weeks post-operative was not only not seen by a doctor, but was discharged without the Consultant in charge's knowledge. I also have concerns about the fact that over 3 appointments at a 'nurse-led' clinic despite there being issues with the chest drain Mr Curran was not once reviewed by a doctor. [redacted] told me that he spoke with the Specialist Sister involved but I am not satisfied that this provides me with adequate assurance that, a) first post-operative reviews and discharges of patients without a doctor seeing

	that patient is not a common and accepted practice, in the main because in many of the answers given to me on this element of the care provided to Mr Curran [redacted] was keen to enlighten me as to how experienced this particular Specialist Sister was. b) and in the circumstances this will not happen again. I had no evidence as to whether or not had [redacted] seen Mr Curran the outcome would have been different. It seems to me that there was at least the possibility that the outcome would have been different. 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. That Wythenshawe Hospital have adopted or condoned a practice whereby first post-operative reviews are conducted by nursing staff (of whatever specialist level of training) without any or any adequate medical overview. 2. That Wythenshawe Hospital have adopted or condoned a practice whereby patients can be, and are, discharged from care at first post-operative review, or indeed any review, by nursing staff (of whatever specialist level of training) without any or any adequate medical overview.
	ACTION SHOULD BE TAKEN In my opinion action should be taken by Wythenshawe Hospital to investigate the circumstances of Mr Curran's discharge from care on 12th February at his first post-operative review without being seen by his operating surgeon, or any other doctor, when he was clearly not recovering well and in line with expectations. Having carried out such an investigation to then set in place a system that would avoid a recurrence of the same, whether or not the patient presents as unwell.
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 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. I have sent a copy of my report to [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	**14.07.2016**	**Mr Andrew Bridgman** **Assistant Coroner**