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.** Mr Andrew Foster, Chief Executive, Wrightington Wigan & Leigh NHS Foundation Trust, Royal Albert Edward Infirmary, Wigan Lane, Wigan, WN1 2NN
1.	**CORONER** I am Simon DA Jones, HM Assistant 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 the 8th October 2016 I commenced an investigation into the death of Margaret Mary Gleeson, a 70 year old lady born on the 5th May 1945. The investigation concluded at the end of the Inquest on the 22nd June 2016. The conclusion of the Inquest was "a rare complication of surgery for incisional hernia repair".
4	**CIRCUMSTANCES OF THE DEATH** The circumstances I found were: Margaret Mary Gleeson underwent an elective incisional hernia repair at the Royal Albert Edward Infirmary, Wigan on the 2nd October 2015, and during the operation sustained a tear to her mesentery, which is a rare complication of this surgery. On her return to the ward, her condition deteriorated and she developed sepsis, although this was not diagnosed until 2344hours on the 3rd October 2015. Following a CT scan which revealed extensive gas at the operation site she was returned to theatre at 0420 hours on the 4th October 2015 where she suffered a cardiac arrest on being anaesthetised. She was resuscitated and underwent an operation to resect the ischaemic bowel, but did not recover from the operation and died on the 4th October 2015 at 1900hours.

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. At the weekend the on call team had to do the job of 4 teams and that it was not possible to provide patients with the care they deserve. In thos circumstances, I consider that staffing levels should be reviewed. 2. The scoring of the MEWS tool on the medical charts had been done inaccurately, and the use of the MEWS tools did not appear to be clearly understood. It would appear that refresher training would assist
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 9th 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 and to the following Interested Persons: 1. [redacted] Leigh Day, Solicitors for the family, Leigh Day Central Park, Northampton Road, Manchester, M40 5BP 2. The Right Hon Jeremy Hunt MP, Secretary of State for Heath, Department of Health, House of Commons, London, SW1A 0AA 3. National Institute for Health and Care Excellence, 10 Spring Gardens, London, SW1A 2BU 4. Care Quality Commission, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA 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 15/07/2016**	**Signed** **Simon D A Jones**