**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1.** Chief Executive of Wrightington, Wigan and Leigh NHS Foundation Trust, Wigan, WN1 2NN |
| 1 | **CORONER**<br><br>I am Rachael Clare Griffin, Assistant Coroner, for the Coroner Area of Manchester West |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 3rd June 2016 I commenced an investigation into the death of Patrick Richard Steer, born on the 29th April 1944.<br><br>The investigation concluded at the end of the Inquest on the 11th November 2016.<br><br>The Medical Cause of Death was:<br><br>Ia Acute Myocardial Infarction<br>b Coronary Artery Disease<br><br>II Malignant Tumour of Intestine (Resected), Right Sub Hepatic Abscess<br><br>The conclusion of the Inquest was that Patrick Richard Steer died as a consequence of naturally occurring disease exacerbated by recognised complications of surgical treatment. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 9th May 2016 the deceased was admitted to the Royal Albert Edward Infirmary, Wigan with abdominal pain. A CT scan revealed a mass in his bowel and he underwent surgery the following day to resect the mass which was cancerous tumour. On the 17th May 2016 he suffered a myocardial infarction and was transferred to the Coronary Care Unit for treatment. On the 25th May it became apparent he had developed a right sub hepatic abscess for which a drain was placed the following day. His condition deteriorated and he died the |

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| | following day. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br>The **MATTERS OF CONCERN** are as follows:<br><br>1. During the inquest evidence was heard that:<br><br>i. Mr Steer had been treated by a number of different clinicians with different expertise including members of the Cardiology team and the Surgical team. He was initially treated by the Surgical team on the surgical ward and was stepped down to ward level care on the 15th May. He was then transferred to the Coronary Care Unit on the 18th May following a myocardial infarction.<br><br>ii. He continued to be reviewed both by the Surgical team and the Coronary Care team on a daily basis, however there was never any liaison between the Surgical Doctors and Coronary Care Doctors. Evidence was given by [redacted] the treating Consultant Surgeon, who confirmed that from her experience communication does not work well between the Doctors on the Surgical team and the Coronary Care team. On the basis of the evidence given I believe this could affect the care provided to patients. She stated that she was not aware of any policy in place within the Trust dealing with the communication between different specialist teams caring for a patient who was under shared care. She explained that there would be benefits if a review was carried out looking at the communications between Doctors when a patient is under shared care.<br><br>I have concerns with regard to the following:<br><br>i. That in circumstances where a patient is under the care of both the Surgical and Coronary Care teams, communication between the Doctors of those teams does not work well and could affect the treatment a patient receives which could lead to a future death.<br><br>ii. I therefore request that a review is undertaken of any policies and procedures in place dealing with the communication between doctors caring for a patient where then is shared care between the Cardiology team and the Surgical team. I would also request that all members of Wrightington, Wigan and Leigh NHS Trust are made aware of the policies and procedures in place dealing with communication between medical staff when dealing with patients under shared care. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, 18th January 2017. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>(1) [redacted], Mr Steer's wife on behalf of the family<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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**<br><br>**23rd November 2016** | **Signed**<br><br>**Rachael C Griffin** |