REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] **2.** [redacted] **3. Chief Executive, Mid Cheshire NHS Trust**
1	**CORONER** I am Nicholas Leslie Rheinberg, senior coroner for the coroner area of Cheshire.
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 3rd May 2016 an investigation was commenced into the death of Charles Ray Woodward aged 67. The investigation concluded at the end of the inquest on 15th December 2016. The conclusion of the inquest was that the deceased who had died as a result of peritonitis caused by virtue of a leaking anastomosis following surgery for cancer of the sigmoid colon had died by misadventure.
4	**CIRCUMSTANCES OF THE DEATH** On 20th April 2016 an operation was performed at Leighton Hospital, Crewe to remove a tumour involving the sigmoid colon. After an apparently uneventful period of recovery the deceased was discharged home from hospital on 22nd April 2016. At home the deceased's health declined. He ate and drank little, he became oliguric, his mobility decreased and it is likely that he had begun to suffer from the peritonitis which subsequently led to his death. Further it is likely that had the deceased remained in hospital the onset of peritonitis would have been recognised and an operation performed which might have saved him.
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. – There was inadequate communication and liaison between the hospital on the one hand and on the other hand the deceased's GP practice and district nurses in the community who, following the deceased's discharge from hospital, would be responsible for the deceased's ongoing care. Further, monitoring of the deceased's condition from Leighton Hospital was insufficiently robust and relied upon oral contact rather than ensuring the physical presence of a medical attendant, be that attendant hospital or community based. The evidence suggested that there was miscommunication between the hospital and the deceased's family with the result that the deceased's worrying decline in health was not appreciated by the hospital.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that you being respectively the Cancer Governance Board and the Chief Executive of Leighton Hospital 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 13th February 2017. 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 namely the family of the deceased and the CQC. 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	**16th December 2016** **Nicholas Leslie Rheinberg** **Senior Coroner**