REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive of Tameside General Hospital NHS Trust**
1	**CORONER** I am Anna Morris Assistant Coroner for **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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 25/07/2017 I commenced an investigation into the death of Mrs. Riaz Begum. The investigation concluded at the end of the inquest 26th January 2018. The conclusion of the inquest was that Mrs Begum underwent a routine laparoscopic cholecystectomy procedure at Tameside General Hospital on 21st June 2017, as a complication of which she developed a bile leak. She was readmitted to Tameside General Hospital on 26th June 2017 on referral from her GP and diagnosed with sepsis. A bile leak was diagnosed after drainage under CT guidance on 5th July 2017 produced bile-stained fluid. Mrs Begum underwent an ERCP to repair the bile leak on 13th July 2017 and developed acute pancreatitis as a complication of that procedure. The severity of that pancreatitis was exacerbated by the pre-existing sepsis and by a delay in diagnosing and repairing the bile leak. Mrs Begum's condition deteriorated and despite treatment for sepsis and multi organ failure she died on 16th July 2017. The medical cause of death was; 1a) Multi-organ failure 1 b) Acute pancreatitis 1 c) Biliary peritonitis 1 d) Recent cholecystectomy and ERCP
4	**CIRCUMSTANCES OF THE DEATH** See above
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) I am concerned that on the 3rd July 2017, a CT Scan indicated the need for fluid drainage to take place under CT guidance. Despite this procedure being deemed necessary, it was not done until the 5th July 2017. The evidence I have heard causes me concern that there were insufficient radiologists/ radiological nurses available to carry out the procedure. (2) I am also concerned that after the 3rd July the need for the drainage to take place was not adequately escalated to Radiology management when [redacted] indicated he could not undertake the procedure within the timescale requested. When the matter was escalated on the 5th July, [redacted] had to be essentially told to do the procedure and offered an additional professional fee. I consider that the lack of availability of suitable capacity for undertaking a drainage procedure in the case of someone being treated for sepsis and possible bile leak puts patients at risk. (3) I am further concerned by the evidence of [redacted] that after took annual leave on the 3rd July, there were no further lists for ERCP procedures until his return on the 11th July . Whilst there may have been other surgical consultants available to review Mrs. Begum whilst he was on leave, his evidence was that once a bile leak was confirmed the ERCP should have taken place and this on his account would not have been possible for 6 days after the leak was diagnosed. I found that this delay played a part in the development of acute pancreatitis in Mrs. Begum and I am concerned that any other delays caused by annual leave being taken may cause further delays for ERCP's for a patient which creates a risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you **The Chief Executive of Tameside General Hospital NHS Trust** 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 6th April 2018. 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 [redacted], son of Riaz Begum. 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	26/01/2018 Signature Anna Morris Anna Morris Assistant Coroner **Manchester South**