REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Walsall Healthcare NHS Trust (Manor Hospital)**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 18 December 2017, I commenced an investigation into the death of Mrs Margaret Spencer. The investigation concluded at the end of the inquest on 22 March 2018. The conclusion of the inquest was a short narrative conclusion of: Died after developing complications arising from a failure to remove a pessary that had been put in place in 2014. A failure to do a timely follow up review due to system failures in IT and administrative input errors contributed to a decline in her condition and these failures and omissions were contributed to by neglect. The cause of death was: 1a Acute Kidney Injury b Hospital Acquired Pneumonia c ll Ischaemic Heart Disease, Frailty, Forgotten Vaginal Pessary
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Spencer was under the care of the Manor Hospital Gynaecology clinic at Manor Hospital. She had regular appointments and review after being diagnosed with a prolapse. This was treated with a pessary. ii) She last saw and was reviewed by her Consultant on the 23 May 2014 and a new pessary given. iii) Due to a change in IT systems no follow up review took place and her condition deteriorated with her reporting frequent urinary tract infections during 2017. iv) This resulted in further hospital admissions and in November 2017 it was discovered that the pessary had eroded through the bladder. v) Sadly despite plans for further surgery her condition continued to decline and she passed away on the 17 December 2017 after developing

	pneumonia and acute kidney injury.
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. Evidence emerged during the inquest that there were failures to properly implement sufficient training for staff during the introduction of a new IT system (Lorenzo). This resulted in the premature closing of her access plan and effectively no further review. This failure to conduct a review led to a number of patients including Mrs Spencer being placed at risk of harm.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. 1. You may wish to consider further reviewing the systems in place to ensure that all relevant patients identified during the relevant period have been identified and further treatment offered as needed. In addition you may wish to review that this IT system change did not result in any other patients across the Trust having their cases closed prematurely.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 28 May 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; Family. 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	**29 March 2018**  **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**