REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **Greater Manchester health & Social Care Partnership and NHS England.**
1	CORONER I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater 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
3	INVESTIGATION and INQUEST On 14th October 2020 I commenced an investigation into the death of Norma Rushworth. The investigation concluded on the 13th May 2021 and the conclusion was one of Narrative: Died from complications of emergency surgery following a previous surgical procedure that had resulted in an abdominal dehiscence due in part to a wound infection not identified prior to the abdominal dehiscence. The medical cause of death was 1a Bronchopneumonia 1b Immobilisation following surgery for Diverticulitis 1c II Ischaemic Heart Disease, Aortic Valve Disease, Hypertensive disease
4	CIRCUMSTANCES OF THE DEATH Norma Rushworth was identified to have a narrowing of the sigmoid due to diverticulitis. She was operated on at Tameside General Hospital initially laparoscopically but then that was not viable through open surgery. The colon was resectioned. She was discharged home. Whilst at home she had an abdominal dehiscence and was admitted back to Tameside General Hospital where she was operated on as an emergency. The dehiscence had occurred as a result of an unidentified infection of the wound, her age and cardio vascular compromise. She developed a chest infection. She had a cardiac arrest when the central line was removed. She was resuscitated and transferred back to the Intensive Care Unit. She continued to deteriorate. On 10th October 2020 she died at Tameside General Hospital. Post mortem examination found she had died from bronchopneumonia with significant underlying heart disease contributing to her death.

5	<u>CORONER'S CONCERNS</u> 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. The inquest heard that due to the pandemic and restrictions Mrs Rushworth was not supported as she would usually have been at outpatient appointments. The inquest heard that this impacted significantly on the quality of the history available to clinicians; support for a vulnerable patient and her decision making. 2. The inquest heard that following her discharge back into the community after surgery support and monitoring was limited notwithstanding how vulnerable she was; the complexity of her surgery and the risk she presented. Advice re management of a patient such as her in the community and risks and management of them was not conveyed clearly to community health professionals and to her family. Covid restrictions meant that communication had been difficult, and the written documentation did not cover the challenges this caused. Her deteriorating health in the community was not as a result recognised at an early stage.
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.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th October 2021. 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 [redacted] (family of the deceased), who may find it useful or of interest. 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	23rd August 2021  **Alison Mutch** **HM Senior Coroner Greater Manchester South**