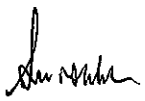
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Aintree Hospitals NHS Trust, Longmoor Lane, Liverpool L9 7AL**
1	**CORONER** I am André Rebello, Senior Coroner, for the area of Liverpool
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	**NVESTIGATION and INQUEST** On 16th May 2013 I commenced an investigation into the death of **Rosa ANDERSON** , Aged **79**. The investigation concluded at the end of the inquest on 17th October 2013. The conclusion of the inquest was Ia Hypoxic Brain Injury Ib Cardiac Arrest Ic Oesophageal Perforation Secondary to Laparoscopic Repair of Diaphragmatic Hernia Accidental Death
4	**CIRCUMSTANCES OF THE DEATH** On 29th April 2013, Rosa Anderson underwent a laparoscopic repair of a diaphragmatic hernia at the University Hospital Aintree. During the procedure, damage was inadvertantly caused to the oesophagus within the thorax. There was no way this could have been appreciated at the time. The following day, Mrs Anderson was discharged home. The same evening she was admitted to the emergency department with abdominal pain and burning in the epigastric region. From the signs and symptoms, the breach of the oesophageal wall was not appreciated. She was referred to the surgical team and a CT Scan was arranged for the next day. With hindsight, the fact that the leaking oesophagus was not detected earlier lessened the chances of a successful resolution. The leaking oesophagus caused mediastenitis, which compromised Mrs Anderson's breathing. This led to a cardiac arrest and hypoxic brain injury on 7th May 2013.
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. – During the course of the Inquest it was evident that Mrs Anderson was not given a discharge summary when discharged on 30th April 2013. Further, she was given no written information about her recent laparoscopic operation, contact telephone numbers for advice, nor were matters highlighted that required urgent medical assistance.
6	**ACTION SHOULD BE TAKEN** In my opinion 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th December 2013. 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: The Family of Mrs Anderson The Coroners Society 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	 **André Rebello** **Senior Coroner for the** **City of Liverpool** **17th October 2013**