REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Mrs Ann Barnes, Chief Executive, Stepping Hill Hospital
1	CORONER I am Alison Mutch, senior coroner, for the coroner area of South Manchester
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 20th February 2017 I commenced an investigation into the death of Glenys Pollitt. The investigation concluded on the 14th August 2017 and the conclusion was one of Narrative: Died as a result of a recognised complication of Boerhaave Syndrome following an operation to repair the oesophageal tear carried out after it had been identified. The medical cause of death was 1a Multi-organ failure;1bBoerhaave syndrome; II Atrial fibrillation
4	CIRCUMSTANCES OF THE DEATH Glenys Pollitt was admitted to Stepping Hill Hospital on the 6th February 2017. She was examined and an x-ray taken at 23:50 on 6th February 2017. She was diagnosed with community acquired pneumonia. A surgical emphysema visible on the x-ray was not identified. She deteriorated. She was seen by a number of clinicians who reviewed her and the x-ray. The surgical emphysema was not identified. On 7th February 2017 at 12.30pm she was reviewed by a consultant who ordered a CT scan and requested critical care input. The scan showed extensive surgical emphysema and a diagnosis of an oesophageal rupture (Boerhaave Syndrome) was made. An emergency operation was carried out on 7th February 2017. She was moved to ICU following the operation. She deteriorated and died on the 16th February 2017 from multi-organ failure.
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. It was accepted during the evidence that the x ray should ideally be viewed on a high-resolution screen rather than an standard screen. This increased the likelihood of significant abnormalities being detected. There are a number of such high-resolution screens for viewing of x rays. The evidence indicated that there was differing practice across the hospital as to when such screens were used and by whom. 2. At the inquest, the evidence given was that the clinicians had seen what they expected to see on the x ray rather than seeing the whole picture shown on the x ray. It was unclear what ongoing programme was in place for reinforcing the lessons learnt from this case amongst clinicians; 3. The process for escalation to consultant level and critical care was unclear.
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 2nd November 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 [redacted] and [redacted], daughters 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	**Alison Mutch OBE** **HM Senior Coroner** **7th September 2017**