REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Mr Simon Shepherd, Executive Director, The Alexandra Hospital • Ms Helen Thompson, Interim Chief Executive, Stockport NHS Foundation Trust • Sir Mike Deegan, Chief Executive, Manchester University NHS Foundation Trust • Professor Stephen Powis, Medical Director, NHS England • Care Quality Commission Copied for interest to. • Husband of Sheila Winifred Ridgway
1	**CORONER** I am Dr Rashid Sohail, assistant coroner, for the coroner area of Manchester City
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** I concluded the inquest into the death of Sheila Winifred Ridgway on 29th June 2018 She died from Ia Multi-organ failure Ib Sepsis secondary to hospital acquired pneumonia II Ischaemic colitis, Arterial disease to both lower limbs treated 13th and 14th December 2016, Thrombolysis to right femoral artery occlusion (secondary to stoppage of antiplatelet medication 21st December 2016), Systemic hypertension, Anaemia
4	**CIRCUMSTANCES OF THE DEATH** The deceased was referred by her GP to the Alexandra Hospital (BMI) on 8th November 2016 with suspected vascular disease to the lower limbs Investigations revealed widespread arterial disease in both her legs She was admitted to the Alexandra Hospital on 13th December 2016 and underwent angioplasty to the diseased blood vessels in both legs There were no post procedural complications and she was discharged home on 15th December 2016 Postoperatively she was commenced on dual antiplatelet therapy to reduce the risk of blockage to the treated arteries The deceased was also under the investigation for blackouts by a cardiologist at the Alexandra Hospital. As part of the investigations it was recommended that the deceased should have the insertion of a loop ECG recorder To reduce the risk of associated bleeding with this procedure the deceased was advised by letter that she should discontinue her dual antiplatelet therapy 5 days prior to admission for this procedure which was planned for on the 21st December 2016 However, there was no communication between the treating surgeon and the cardiologist as to the necessity for continuing with the dual antiplatelet therapy with regards to any ongoing risks of arterial occlusion in the legs. The deceased was admitted to Wythenshawe Hospital on 20th December 2017 with a painful, cold pulseless right leg Investigations revealed occlusion of the previously

	treated right superficial femoral artery, and on 21st December she underwent successful thrombolysis treatment for this. Post thrombolysis treatment she was once again commenced on dual antiplatelet treatment. On 27th December 2017 she developed diarrhoea, for which investigations and treatment were commenced She was reviewed by the gastroenterology team and a CT abdomen was requested which revealed non-specific inflammatory change, most likely infective in nature Advice was sought from the consultant microbiologist regarding the appropriate antibiotics to treat this The administration of the antibiotic treatment appears to have been delayed due to a failure to order the necessary antibiotic Evidence subsequently given by a different consultant microbiologist from within the same hospital stated that bacterial culture results (which were only available after the deceased's death) showed that the organism cultured was not susceptible to the antibiotic initially recommended The delay in administration of the recommended antibiotic was therefore unlikely to have been significant. The deceased was also commenced on intravenous fluids, but evidence was heard of omissions and poor documentation in relation to this Despite ongoing treatment the deceased's condition deteriorated with evidence of deteriorating renal function, low blood pressure and worsening of inflammatory markers on blood tests The deceased was seen by the intensive care and outreach teams on 9 December 2017 At this time she was found to have developed multi-organ failure due to sepsis A CT abdomen and pelvis revealed left lung consolidation consistent with pneumonia and chronic ischaemic colitis It was deemed that escalation of medical treatment would be futile and not in the best interests of the deceased The deceased was referred to the palliative care team for her ongoing care The deceased died at 16.10hrs on 9 January 2017
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) Communication between speciality consultants – lack of any system to ensure that communication occurs between the treating consultants as to the necessity for identifying and documenting any potential ongoing risks when speciality specific treatments are being contemplated or planned for the different specialities simultaneously
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 11 September 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 Interested Persons I have also sent it to organisations 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	**16th July 2018** **Dr Rashid Sohail**