**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO: The Secretary of State for Health |
| 1 | CORONER<br><br>I am Alison Mutch ,Senior Coroner, for the coroner area of South Manchester |
| 2 | CORONER'S LEGAL POWERS<br><br>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<br><br>On 21st August 2017 I commenced an investigation into the death of Mary Barbara Ryder. The investigation concluded on the 26th September2018 and the conclusion was one of short narrative-Died from a pulmonary embolism - a recognised complication of necessary cancer surgery diagnosed on admission to Tameside General Hospital and exacerbated by an infection of her surgical wound.<br><br>The medical cause of death was 1a Pulmonary embolism 1bSurgery for bladder cancer<br>II Resection of bladder cancer |
| 4 | Mary Barbara Ryder was diagnosed with bladder cancer. She underwent surgery on 10th July 2017 at Stepping Hill Hospital. Post-operatively she was given Clexane for 28 days. She was discharged on 27th July 2017. She self-administered Clexane for the remaining period of 10 days. Further Clexane was not prescribed. Her mobility remained decreased. There was no further clinical review regarding Clexane. Her wound was large and was treated in the community by the District Nursing Team in |

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| | accordance with the Tissue Viability Service Plan. On 18th August 2017 she saw the surgical consultant. He referred her for an out-patient CTPA. NICE guidance states that in such a situation, a D-dimer should be obtained - one was not done. Her would was clean and healthy and she returned home. On 19th August 2017 her health deteriorated significantly. On 20th August 2017 she had pronounced chest pains and was admitted to Tameside General Hospital.<br><br>It was identified that her wound was infected. Antibiotics were given. Her D-dimer was very high and a pulmonary embolism was diagnosed. Anticoagulation was given. She deteriorated rapidly on the evening of 20th August 2017. She died on 21st August 2017 at Tameside General Hospital. |
| 5 | <u>CORONER'S CONCERNS</u><br><br>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.<br><br>The MATTERS OF CONCERN are as follows. –<br>The inquest heard that:<br>The guidance nationally is to prescribe clexane for 28 days after an operation. However, the guidance does not suggest that some cases may require longer where a patients mobility remains reduced. There does not appear to be an emphasis on the need to review the situation throughout the post-operative period after a discharge home. |
| 6 | ACTION SHOULD BE TAKEN<br><br>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<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd November 2018. I, the coroner, may extend the period. |

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| | 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<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted] daughter of Mary Ryder, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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<br>HM Senior Coroner<br>27.09.2018  |