REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Sir Michael Deegan, Chief Executive, MFT • [redacted], Joint Medical Director, MFT • [redacted], Joint Medical Director, MFT Copied for interest to: • Chief Coroner • Next of kin
1	**CORONER** I am Ms Jean Harkin, HM Assistant Coroner for the Manchester City Area.
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	**INQUEST** I concluded the inquest into the death of **Margaret Bernadette WILSON** on **17 July 2018** and recorded that he/she died from: 1a Cardiac failure and arrest 1b Acute myocardial infarction and acute aortic valve endocarditis (with surgical intervention on July 18th 2017).
4	**CIRCUMSTANCES OF THE DEATH** Mrs Wilson was admitted to Trafford General Hospital Urgent Care centre on the 18th of June 2017 complaining of swelling and pain in her right arm and shoulder, she also had bruising and swelling of her index and middle finger for four days. She was provisionally diagnosed with cellulitis and antibiotics were started. Of note, no blood tests were performed prior to commencing antibiotics. On the 2nd of July 2017 the deceased complained of central crushing chest pain and was transferred to Manchester Royal infirmary. Endocarditis was then diagnosed however, despite treatment, the deceased failed to respond and died on 20th July 2017.

	I attach a copy of the record of inquest confirming the cause of death. Evidence heard at the Inquest confirmed that a blood test ought to have been performed prior to the prescribing of antibiotics.
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. A blood test should have been done, in compliance with national guidelines, which would have confirmed Endocarditis. The absence of such test and the prescribing of antibiotics masked the disease. 2. Earlier diagnosis and treatment would more likely than not have resulted in a different outcome. In addition it was later recognised that the finger symptoms were most likely due to Endocarditis.
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 **Tuesday 7th May 2019**. 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	**DATE:** **11th March 2019** **Signed:**	**NAME OF CORONER:** **Ms Jean Harkin** HM Assistant Coroner for Manchester City Area