REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Chief Executive Officer, Circle Healthgroup Ltd. 1st Floor, 30 Cannon Street, London EC4M 6XH.

CORONER

I am Chris Morris, Area Coroner for Greater Manchester (South).

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 18TH April 2024, I opened an inquest into the death of Terence Grainger, who died on 10th February 2024 at The Alexandra Hospital, Cheadle, aged 61 years. The investigation concluded with an inquest which I heard on 22nd and 24th January, and 4th February 2025.

A post mortem examination determined Mr Grainger died as a consequence of:-

1) **a) Acute left thoracic cavity haemorrhage**
b) Removal of left-sided intercostal drain
c) Drainage of pleural effusion following coronary artery bypass graft surgery for ischaemic heart disease due to coronary artery atheroma.

The conclusion of the inquest was a Narrative Conclusion, to the effect that Mr Grainger died as a consequence of complications arising from chest drain insertion under ultrasound guidance, which first became apparent after the chest drain had been removed.

CIRCUMSTANCES OF THE DEATH

Mr Grainger died on 10th February 2024 at The Alexandra Hospital, Cheadle as a consequence of an acute left thoracic cavity haemorrhage due to removal of a left-sided intercostal drain which had been placed to drain a pleural effusion following coronary artery bypass graft surgery.

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. –

I am concerned that notwithstanding the limited steps Circle Healthgroup Ltd has taken towards introducing electronic patient records at its hospitals, the court heard evidence that no plans are currently in place to introduce an electronic system for recording patient observations.

I am concerned that an ongoing risk of future deaths arises from this position, in the view of the potential for such systems to accurately record timings of observations, facilitate trend analysis particularly in the context of a deteriorating patient, and reduce the potential for errors, either arising from incorrect / unclear manual recording of observations or miscalculating the NEWS 2 score.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **2nd April 2025**. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, together with [redacted] on behalf of Mr Grainger's family, and the Medical and Dental Defence Union of Scotland and [redacted] on behalf of the other Interested Persons.

I have also sent a copy to the Care Quality Commission 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.

Dated: **5th February 2025**

Signature: Chris Morris, Area Coroner, Manchester South.