REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Manchester University NHS Foundation Trust
1	**CORONER** I am Anna Morris KC, Assistant Coroner for the Coroner Area of Greater Manchester South.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 19th December 2024, I commenced an investigation into the death of Honoria Culshaw. On the 11th September 2025 I heard the inquest touching on her death. On that date I returned a narrative conclusion as follows: **The deceased died from pneumonia which she developed following treatment for sepsis which originated from an infected pacemaker site. Her underlying cardiac and immunological conditions contributed to her deterioration following necessary surgery on the 16th September 2024 to extract her pacemaker and made it more likely that she would contract a fatal pneumonia.**
4	At the Inquest on the 11th September 2025 I made the following findings: I found that the Mrs. Culshaw had a pacemaker fitted in 2013 to support her heart function. In November 2023 the pacemaker's batteries were replaced in a surgical procedure. In March 2024 the deceased presented to her GP with signs of infection at the site of the surgical wound. In July 2024 the deceased presented to Wythenshawe Hospital with opening of her wound. This was likely evidence of a systemic infection arising from the pacemaker site and guidance indicates that consideration should have been given to extracting and replacing the pacemaker to remove the infection. She was advised to attend Royal Preston Hospital, her pacemaker care centre.

	At the Royal Preston Hospital, a decision was made to manage the wound conservatively by re-siting the pacemaker box and prescribing anti-biotics. On the 15th August 2024 a swab came back positive for *Morganella Morganii* bacteria. It is not clear on the evidence who on the clinical team was aware of these results before the deceased underwent surgery on the 20th August to reposition her pacemaker. She was prescribed anti-biotics in any event that would have been appropriate to treat this particular bacteria. She was seen by a Consultant Cardiologist on the 3rd September 2024 who observed that the wound was healing and there were no clinical signs of infection. On the 9th September 2024, the Mrs. Culshaw presented again at Wythenshawe with further deterioration of her pacemaker wound and sepsis. She underwent an extraction procedure on the 16th September 2024 to remove the pacemaker and prescribed antibiotics. She completed the course of anti-biotics, but then developed a widespread acute rash, which was probably a reaction to the anti-biotics. She was also found to have suffered a pulmonary embolus, a known complication of pacemaker extraction surgery. Despite appropriate post-surgical interventions and treatment, the deceased's condition began to deteriorate around the 10th October 2024. I find that the deceased's exposure to repeated and persistent infections and sepsis, together with the physiological trauma of necessary surgery for pacemaker extraction and her inflammatory reaction to appropriate anti-biotic treatment is likely to have placed an unsustainable load on her cardio-respiratory system. The deceased's physiological reserves were depleted by her chronic Idiopathic Thrombocytopenic Purpura and her underlying heart conditions. The deceased was placed on a palliative care pathway and discharged to her own home, where she died on the 25th October 2024. On the basis of the pathological evidence, I find that following her discharge, the deceased developed a pneumonia, in light of her co-morbidities and recent medical interventions, was fatal.

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. – Mrs. Culshaw attended Wythenshaw Hospital on the 10th July 2024 an presented with an opening of her pacemaker scar. I heard evidence at the inquest from [redacted] a Consultant Cardiologist at Wythenshawe that International clinical guidance indicates that any opening of an implantation scar should be interpreted as a sign of systemic infection of the wound and that extraction and replacement of the pacemaker should follow in order to remove the infection. This was the advice of the on-call Cardiologist at Wythenshawe on the 10th July 2024 to the Emergency Department medical team. I heard evidence that Wythenshawe is one a limited number of specialist surgical centres for the extraction of pacemakers. Mrs. Culshaw was not admitted to Wythenshawe Hospital, but discharged to the care of Royal Preston Hospital, where her pacemaker had been fitted. Royal Preston Hosptial is not a specialist surgical centre for pacemaker extraction. The expectation of Wythenshawe Hosptial at the time of her discharge appears to be that Royal Preston would refer her back to Wythenshawe for extraction. However, the need for extraction and therefore a referral was not communicated by Wythenshawe to either Royal Preston or to Mrs. Culshaw's GP. It is not clear that it was adequately explained to Mrs. Culshaw's family. Mrs. Culshaw re-presented at Wythenshawe on the 9th September, again with signs of infection and underwent an extraction procedure as an inpatient on the 16th September 2024. However, I found that her experienced of persistent and prolonged infection depleted her physiological reserve and contributed to her succumbing to a fatal pneumonia on the 25th October 2024. I am concerned that this lack of information sharing along a communication pathway between the Cardiology department and specialist surgical extraction team at Wythenshawe and the Cardiology departments at local treating hospitals risks such referrals being delayed or not being made at all, as happened in the present case.
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, **19th November 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely – 1. Mrs Culshaw's Family 2. Royal Preston Hospital – Lancashire Teaching Hospitals Foundation Trust 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 from. 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.
	Signed: 
	Dated: **24th September 2025**