REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Pennine Acute Trust **2.** The Chief Medical Officer England & Wales **3.** The Chief Coroner **4.** Family of the deceased
1	**CORONER** I am the Senior Coroner, for the coroner area of Manchester North
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 17/08/2012 I commenced an investigation into the death of Derek BRIERLEY, then aged 86 Years. The investigation was concluded at the end of the inquest on 17/08/2013. The conclusion of the inquest was "Recognised but rare complication of necessary surgical intervention.", the medical cause of death being 1a Bronchopneumonia 1b post peritonitis after insertion of superapubic catheter for benign prostatic hyperplasia 1c blocked urethral catheter for benign prostatic hyperplasia
4	**CIRCUMSTANCES OF DEATH** Mr Brierly's catheter was not working on the morning of the 21st July 2012. A district nurse was unable to recatheterise him at home and so he was conveyed by ambulance to the Royal Oldham Hospital where three further attempts by a nurse, junior doctor and consultant were also unsuccessful by which time Mr Brierly had a palpably distended bladder. The Consultant's attempt at a suprapubic insertion via the abdomen was abandoned following which Mr Brierly became acutely unwell with features of peritonitis
5	**<u>CORONER'S CONCERNS</u>** 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) Although the consultant performing the suprapubic procedure had done so successfully on nine previous occasions the last such occasion was twelve months earlier. The family overheard instructions for the procedure being read out to the consultant whilst it was being carried out. More likely than not the site of the insertion was too high.

	2) There are no Trust Guidelines as to the standard of competence or training of those carrying out the procedure 3)Difficulties were encountered in locating a suprapubic catheter prior to the procedure
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (AND/OR 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 the 24th of November 2013 . 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. 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.
9	20 August 2013. Signed Simon Nelson