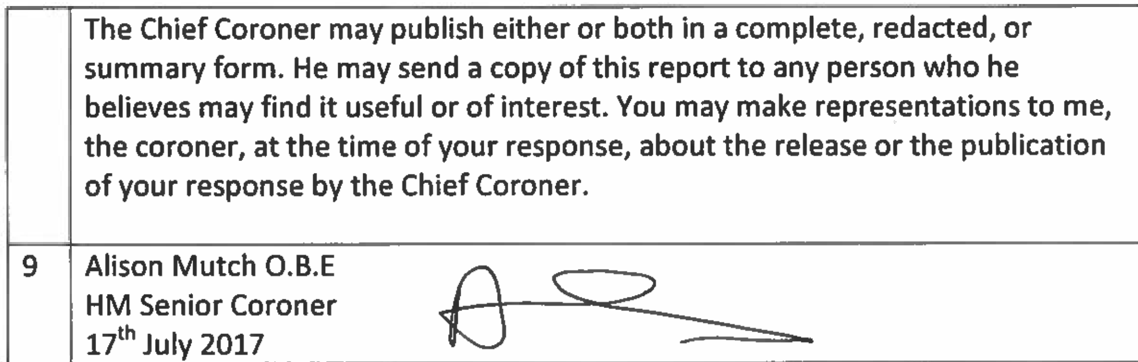
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of Tameside and Glossop Integrated Care NHS Foundation Trust
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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	INVESTIGATION and INQUEST On 5th October 2016 I commenced an investigation into the death of Matthew Robert Edwards .The investigation concluded on the 7th June 2016 and the conclusion was one of Narrative: Died as a result of a complication of aortic dissection for which hypertension is a recognised contributory factor. The medical cause of death 1a Cardiac tamponade secondary to haemopericardium;1bAortic dissection;II Hypertension
4	Matthew Robert Edwards had a history of hypertension and a family history of aortic complications. He was prescribed medication to assist with controlling his hypertension. As a result of side effects he stopped taking his medication. In February 2016 he was discharged from Tameside General Hospital. A discharge summary was sent to his GP in July 2016. As part of his discharge planning referrals were to be made for further investigations including echocardiogram. The referrals were not made. On the 17th September 2016 Matthew Robert Edwards attended Southport A&E complaining of chest pain. The preliminary view was of gastroenteritis but further tests were ordered. Matthew Robert Edwards left the hospital before all of the results were available. He was not notified he had a raised troponin level. On the 21st September 2016 he went to A&E at Tameside General Hospital with central chest pain. A pulmonary embolism was suspected and he was referred for further tests. He was reviewed on the 22nd September 2016 and a CT angiogram was booked for the following

	week. On the 25th September 2016 he was found dead at his home address, 25 Coombes Avenue, Hyde.
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.Matthew Edwards was discharged from Tameside Hospital in February 2016. The discharge summary was not dispatched until July 2016. The evidence was that this was not a one off difficulty and that a significant backlog had developed with discharge summaries routinely being dispatched many months after discharge. As a result, Matthew Edwards GP was not notified about his period as an in patient. When he attended a subsequent GP appointment, she was unclear about the discharge plan for Mr Edwards and the rationale for it. 2. The follow up appointment was not made for Mr Edwards on his discharge. When the discharge summary was dispatched subsequently this was not picked up on and there was no system in place to ensure that follow up appointments had been booked prior to discharge. 3. There was a delay of at least 1 week for a CT angiogram. This was due to a shortage of slots. As a result the diagnosis of a possible embolism was not ruled out at an early stage.
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, namely by 11th September 2017. 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 [redacted], father of the deceased, 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, 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 O.B.E HM Senior Coroner 17th July 2017