REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Medical Director, Wythenshawe Hospital**
1	**CORONER** I am Rachel Galloway, assistant 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 the 12th September 2017 an investigation was commenced into the death of Kenneth Longley .Subsequently an inquest was opened on the 19th September 2017 and concluded on the 15th February 2018. The medical cause of death was found to be: 1a massive spontaneous upper gastrointestinal haemorrhage 1b. Anticoagulation therapy for myocardial infarction II Myocardial Infarction, Aortic stenosis
4	**CIRCUMSTANCES OF THE DEATH** **Mr Longley died on the 9/9/17. On the 27th April 2017 he suffered a collapse and attended Wythenshawe hospital. He was discharged with an echocardiogram to be undertaken. The echocardiogram was carried out on the 16th May 2017, which confirmed severe aortic stenosis. [redacted] referred Mr Longley back to his GP in order that the GP might refer Mr Longley to the Cardiology Department at his local hospital. The said letter was only signed on the 7th August 2017 and was received by the GP surgery (who then took no further action) on the 7th August 2017. A separate Regulation 28 Report has been sent to the GP surgery. The letter was therefore sent out nearly 3 months following the original echocardiogram in May 2017.** **In September 2017 Mr Longley suffered a further collapse and was admitted to the Acute Coronary Unit at Tameside Hospital. Mr Longley was found to have acute coronary syndrome as well as severe aortic stenosis. He was given anticoagulation therapy to treat the acute coronary syndrome (as there had been a rupture of the lining of the artery which had caused a partial blockage). Unfortunately, the necessary anticoagulation treatment led to an upper gastrointestinal bleed and Mr Longley's death at Tameside Hospital on the 9th September 2017.**
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. – The letter from Doctor [redacted] to Mr Longley's GP was sent out on the 7th August 2017, nearly 3 months following the echocardiogram on the 16th May 2017. This appears to be a significant delay. [redacted] explained in evidence that there had been a delay in obtaining the medical records needed for [redacted] to write the report to the GP but the cause of that delay was not known. It was not clear why the letter was only written on the 29th July 2017 and then not sent out until the 7th August 2017. Mr Longley had severe aortic stenosis. The evidence suggested that cardiac surgery would have been offered to Mr Longley and would have taken place within 3-6 months. In this case, it was not possible to determine whether the outcome would have been different for Mr Longley had the letter been sent out in a timely fashion. The concern is that there is a risk of future death if there is a delay in sending out similar letters in the future.
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 17th May 2018. The assistant 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 the family of Mr Longley, 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	**Rachel Galloway** **HM Assistant Coroner** **22/03/2018**

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted], Partners at the Cornerstone Family Practice, Graham Street, Beswick, Manchester M11 3AA**
1	**CORONER** I am Rachel Galloway, assistant 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 the 12th September 2017 an investigation was commenced into the death of Kenneth Longley .Subsequently an inquest was opened on the 19th September 2017 and concluded on the 15th February 2018. The medical cause of death was found to be: 1a massive spontaneous upper gastrointestinal haemorrhage 1b. Anticoagulation therapy for myocardial infarction II Myocardial Infarction, Aortic stenosis
4	**CIRCUMSTANCES OF THE DEATH** **Mr Longley died on the 9/9/17. On the 27th April 2017 he suffered a collapse and attended Wythenshawe hospital. He was discharged with an echocardiogram to be undertaken. The echocardiogram was carried out on the 16th May 2017, which confirmed severe aortic stenosis. [redacted] referred Mr Longley back to his GP in order that the GP might refer Mr Longley to the Cardiology Department at his local hospital. The said letter was only signed on the 7th August 2017 and was received by the GP surgery on the 7th August 2017. A separate Regulation 28 Report has been sent to Wythenshawe Hospital.** **[redacted] explained in evidence that, whilst the surgery had received the letter from [redacted] on the 7th August 2017, it had been allocated to a GP to action who had then not picked it up until October 2017 (after Mr Longley's death).** **In September 2017 Mr Longley suffered a further collapse and was admitted to the Acute Coronary Unit at Tameside Hospital. Mr Longley was found to have acute coronary syndrome as well as severe aortic stenosis. He was given anticoagulation therapy to treat the acute coronary syndrome (as there had been a rupture of the lining of the artery which had caused a partial blockage). Unfortunately, the necessary anticoagulation treatment led to an upper gastrointestinal bleed and Mr Longley's death at Tameside Hospital on the 9th September 2017.**
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. – The letter from [redacted], which was received by the GP surgery on the 7th August 2017, referred to an echocardiogram on the 16th May 2017 which confirmed severe aortic stenosis. [redacted] asked that the GP consider referring Mr Longley for a specialist cardiology opinion and for him to be reassessed by the GP regarding any further syncopal episodes. The concern is that no action was taken by any GP at the practice to either refer Mr Longley to Cardiology in light of Dr Chambers' letter or in light of the reported echocardiogram results. Further, no action was taken by any GP to review Mr Longley as requested. The concern is that there is a risk of future deaths if similar lack of action occurs in the future.
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 the 17th May 2018. The assistant 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 the family of Mr Longley, 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	**Rachel Galloway** **HM Assistant Coroner** **22/03/2018**