REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: NHS Stockport Clinical Commissioning Group
1	CORONER I am Alison Mutch, Senior 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 Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	INVESTIGATION and INQUEST On 19th February 2020 I commenced an investigation into the death of Brian Richard Murphy. The investigation concluded on the 24th July 2020 and the conclusion was one of **Narrative: Died from the recognised complications of congestive cardiac failure and a myocardial infarction whilst awaiting a cardiology appointment.** The medical cause of death was **1a) Pulmonary oedema; 1b) Myocardial infarction on a background of Congestive cardiac failure; 1c) Coronary artery disease; II) Idiopathic pulmonary fibrosis, Community acquired pneumonia, Chronic obstructive pulmonary disease.**
4	CIRCUMSTANCES OF THE DEATH Brian Richard Murphy was a long-term smoker and had diabetes. He saw a GP with shortness of breath. A chest x-ray and blood tests were arranged and showed signs of congestive cardiac failure. An Echocardiogram was requested. A CT scan showed significant coronary artery narrowing. The results of the Echocardiogram were reported, and he was referred on 6th February by his GP to the cardiology clinic. On 12th February he deteriorated suddenly. He was admitted to Stepping Hill Hospital. He had an acute myocardial infarction. He deteriorated further. On 17th February 2020 he died at Stepping Hill Hospital.
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. – The inquest heard that the system for referrals for cardiology tests meant that there were delays in tests being carried out which led to delays in patients being referred to the cardiology clinic to see a cardiologist.

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 27th November 2020. 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 Mrs [redacted], wife of the deceased, and Brinnington Health Centre, 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	**Alison Mutch** **HM Senior Coroner** **02.10.2020**