REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Greater Manchester Health and Social Care Partnership
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 3rd December 2021 I commenced an investigation into the death of John Edward Kay. The investigation concluded on the 24th June 2022 and the conclusion was one of **Narrative: Died as a consequence of the recognised complications of previous necessary surgery**. The medical cause of death was **1a) Recurrent Aspiration Pneumonia; 1b) Leaking Trachea-Oesophageal Fistula; 1c) Oesophageal Stricture related to treatment (surgery and radiotherapy) for Laryngeal Carcinoma; II) Chronic Obstructive Pulmonary Disease**
4	CIRCUMSTANCES OF THE DEATH John Edward Kay had his larynx removed for stage 4 cancer in 2010. A speech valve was put in place. He had Chronic Obstructive Pulmonary Disease and significantly reduced respiratory lung function. He was admitted to Stepping Hill Hospital where he had a series of aspiration pneumonias. He continued to deteriorate and died at Stepping Hill Hospital on 26th November 2021.
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. The Inquest heard evidence that the management of a patient with

	a valve such as Mr Kay had is a complex one. It requires regular monitoring and replacement. The evidence was that when he went into a care home that information about how to care for his valve was not shared with the care home. The consequence was that he was not seen or referred for regular replacements of the valve which increased the risk of the valve not functioning correctly and him developing aspiration pneumonia; 2. The role and support available from the specialist nurse service was not understood within the community including by the GP. Greater understanding and awareness of that role would have been helpful in managing Mr Kay and reducing the risk.
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 **29th September 2022**. 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] on behalf of the Family, 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**  **04.08.22**