REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health and Social Care, 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 12th October 2021 I commenced an investigation into the death of Philip Jones. The investigation concluded on the 30th May 2022 and the conclusion was one of **Natural Causes**. The medical cause of death was **1a) Bronchopneumonia; 1b) Motor Neurone Disease**
4	CIRCUMSTANCES OF THE DEATH Philip Jones, in February 2021 started to have symptoms that included difficulty in swallowing. He lost a significant amount of weight over the course of the following months and his overall health deteriorated. In September 2021 he was admitted to Tameside General Hospital and clinical assessment concluded he had Motor Neurone Disease. He was transferred to Salford Royal Hospital where he developed bronchopneumonia. He deteriorated and was discharged home. He died at his home address on 9th October 2021 from bronchopneumonia. Post-mortem examination confirmed the diagnosis of Motor Neurone Disease.
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 there were significant backlogs in appointments to see a neurologist due to a national shortage of clinicians and appointments. In Mr Jones' case this had not impacted the overall outcome but the Inquest heard evidence that this would not necessarily be the case in all patients. The Inquest heard that pre-pandemic, there was a backlog in existence at 3,500 patients waiting for a neurology appointment. The figure at the time of the Inquest was approx. 7,000; 2. The Inquest heard evidence that incompatible/different IT systems at the District General Hospital and Tertiary Centre made communication and information sharing in relation to patients more difficult. This impacted the holistic view that clinicians needed of an individual patient. Whilst images could be shared there was no ability for notes for one Trust to be visible to a clinician at another Trust; 3. The Inquest heard that there were delays in communications from consultants to other clinicians e.g. GPs and patients following appointments/assessments due to a shortage of administrative support for consultants. This meant that important diagnostic/treatment information about patients was not shared expeditiously.
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 12th October 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**  **17.08.22**