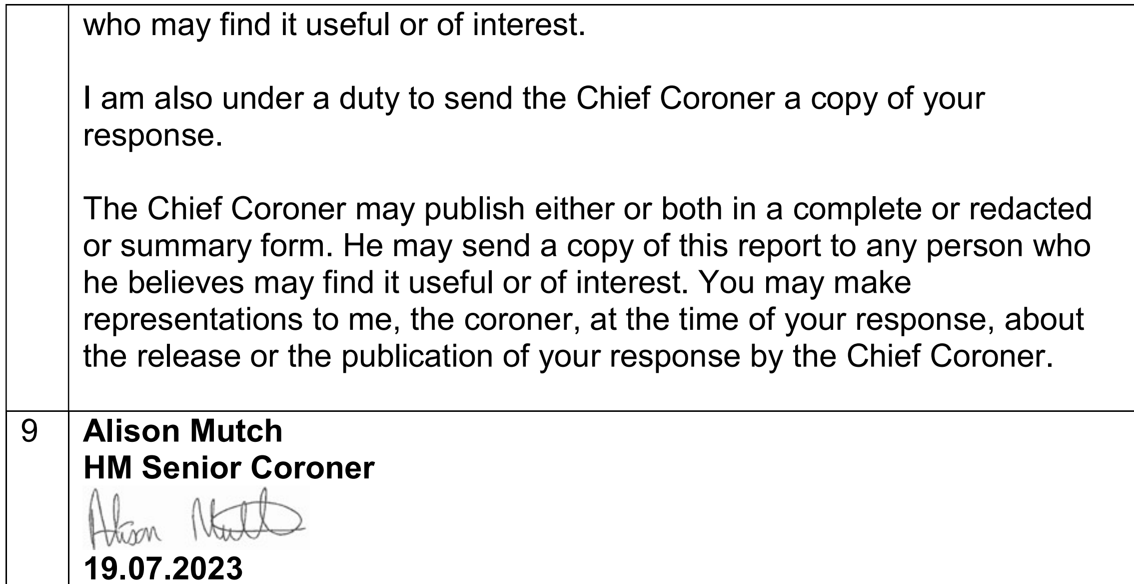
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Integrated Care
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 6th December 2022 I commenced an investigation into the death of Michael Kevin Amesbury. The investigation concluded on the 25th May 2023 and the conclusion was one of **Narrative: Died from a combination of bronchopneumonia (not diagnosed until after death) and aspiration of gastric contents exacerbated by heart failure for which he was awaiting assessment regarding his suitability for surgical intervention.** The medical cause of death was **1a) Bilateral Bronchopneumonia and aspiration of gastric contents; II) Heart Failure, Diabetes Mellitus, Dapagliflozin therapy**
4	CIRCUMSTANCES OF THE DEATH Michael Kevin Amesbury had an extensive cardiac history. He was becoming increasingly unwell as a consequence. On 24th October 2022 he had a trans-oesophageal echocardiogram that confirmed he had severe mitral regurgitation. He was referred to Wythenshawe Hospital for surgical assessment. Whilst awaiting assessment he became increasingly unwell. He was prescribed Dapagliflozin medication which led to a rapid rise in his ketones and he became increasingly unwell. He was admitted to Tameside General Hospital on 30th November 2022 .Whilst an in-patient at Tameside General Hospital he became unresponsive. Cardiopulmonary resuscitation was undertaken during which there was severe vomiting of gastric contents. He died at Tameside General Hospital on 30th November 2022. Post-mortem examination confirmed he had died from bilateral bronchopneumonia (not diagnosed in life) in combination with extensive aspiration of gastric contents. He had extensive evidence of heart failure which on the balance of

	possibilities contributed to his reduced physiological reserves and to his death.
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. The inquest heard evidence that Mr Amesbury needed to be referred from secondary to tertiary services within Greater Manchester. The inquest heard evidence that the speed and quality of that referral was impacted by the way in which information was shared between clinicians in different trusts within Greater Manchester. The use of different systems and reliance on postal services and lack of a clear, effective electronic system of referrals including transfer of images /notes meant there were delays in assessing patients which led to a delay in formulating a treatment plan in tertiary services; 2. The evidence also indicated that there were delays in patients who had been identified as requiring cardiology input being seen in cardiology clinics due to availability of clinicians/appointment slots inquest. This was exacerbated where there was a need for trans-oesophageal echocardiogram due to resource issues. The inquest heard that this type of echocardiogram could be key in understanding the cardiac issues of a patient.
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 13th September 2023. 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 **1) [redacted] on behalf of the Family; 2) Tameside General Hospital; 3) Wythenshawe Hospital**,



	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** [signature] **19.07.2023**