**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO: NHS England |
| 1 | CORONER<br><br>I am Alison Mutch, HM Senior Coroner, for the coroner area of South Manchester |
| 2 | CORONER'S LEGAL POWERS<br><br>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<br><br>On 9th May 2023 I commenced an investigation into the death of Holly May Mullan. The investigation concluded on the 29th September 2023 and the conclusion was one of **Narrative: Died from the complications of suspension from a ligature whilst under the influence of alcohol.** The medical cause of death was **1a) Hanging** |
| 4 | CIRCUMSTANCES OF THE DEATH<br><br>Holly May Mullan had longstanding severe abdominal pain. She had long delays waiting for medical appointments to see gynaecologists and gastroenterologists due to long waiting lists. At times she accessed private consultations to try and obtain insight into and relief from her pain. On 7th May 2023 Holly May Mullan was found at 3 Napier Road attached to a ligature. Police enquiries found no suspicious circumstances and no evidence of third-party involvement. Post-mortem examination found she was significantly under the influence of alcohol at the time of her death. |
| 5 | <u>CORONER'S CONCERNS</u><br><br>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.<br><br>The MATTERS OF CONCERN are as follows. –<br><br>The inquest heard evidence of the distress caused to Holly and the impact on her health by the long waits to be seen by gastroenterologists and gynaecologists within the NHS. The evidence heard was that post-Covid, the waiting times to be seen in both specialities unless the referral |

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| | was on the two-week cancer wait had grown significantly across England. As an illustration the inquest was told that pre-Covid, the average wait for a routine gynaecology referral was 18 weeks. Now in England the wait was often in excess of 12 months. Even an urgent referral would often involve a wait of over 40 weeks. This was leading to delays in diagnosis and treatment even in those with significant/severe health conditions. |
| 6 | ACTION SHOULD BE TAKEN<br><br>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<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th December 2023. I, the coroner, may extend the period.<br><br>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<br><br>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 and; 2) Stockport NHS Foundation Trust, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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**<br>**HM Senior Coroner**<br>  <br><br>**17.10.2023** |