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, HM Senior Coroner, for the coroner area of South Manchester
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 21st March 2023 I commenced an investigation into the death of Terence Briney. The investigation concluded on the 8th December 2023 and the conclusion was one of **Natural Causes**. The medical cause of death was **1a) Acute respiratory event on the background of an aspiration 1b) Frailty II) Myocardial Infarction, Ischaemic Heart disease and Aortic Stenosis**
4	**CIRCUMSTANCES OF THE DEATH** Terence Briney's health began to deteriorate significantly from July 2022. His appetite reduced, he had increasing lethargy and developed tremors. He began to lose weight. No investigations were carried out until he was referred to gastroenterology on the cancer pathway. He was very frail by the time of the referral. The tests indicated his oesophagus was not functioning effectively but there was no clear cause. He was admitted to Stepping Hill Hospital on 15th March 2023 after the GP examined him and was concerned about how frail he was. On admission no clear reversible cause was identified. He was put on Nil by Mouth due to his poor oesophageal functionality. He presented a high risk of aspiration. On the balance of probabilities, the deterioration in his oesophageal function was due to an undiagnosed neurological condition. On 17th March he suffered an acute respiratory event due to aspirating on his saliva. He died at Stepping Hill Hospital on 17th March as a consequence.

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. – The inquest heard evidence that symptoms raised by Mr Briney and his family were attributed to old age rather than a possible neurological disease. The evidence before the inquest was that there were situations where clinicians would attribute a deterioration to the aging process rather than consider the whole picture and investigate if there was a treatable condition. This presented a risk that treatable conditions in the elderly could be missed.
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 25th March 2024. 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 and; 2) Stockport NHS Foundation Trust, 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**  **29.01.2024**