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 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 25th September 2023 I commenced an investigation into the death of Alan William Rowland Smith. The investigation concluded on the 8th February 2024 and the conclusion was one of **narrative: Died from the complications of chronic venous insufficiency when the severity of his condition was not recognised at an early stage and there was not an early referral to vascular services.** The medical cause of death was **1a) Frailty 1b) Infected Leg 1c) Chronic Venous Insufficiency on a background of past thrombotic syndrome**
4	CIRCUMSTANCES OF THE DEATH Alan William Rowland Smith developed severe leg swelling as a consequence of venous insufficiency following a probable venous thrombosis. He developed an infected leg and he deteriorated rapidly. He died at Stepping Hill Hospital on 17th September 2023. The severity and risk posed by the swelling was not recognised at an early stage and as a consequence early interventions to reduce swelling and reduce the risk of deterioration and death did not take place.
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 a prompt referral to vascular services was important in cases such as these, where GPs would have limited expertise in managing the risks and offering effective treatments. The need for early referral was not, the inquest was told, widely understood.

2. Where such referrals were made it was essential that sufficient detail be provided to ensure that the degree of risk could be accurately assessed and effective prioritisation could take place.

3. The inquest was told that as well as referral to vascular services it was important that GPs understood that District Nurses were a resource that should be utilised with prompt referrals. This could be challenging as the District Nursing Service was under huge pressure due to demand. However, they were well used to recognising high risk patients and clearer guidance for GPs around when to refer would ensure that their expertise would be available at an early stage. Management of any case such as Mr Smith's would of necessity involve the District Nursing Team as compression bandaging was the most effective treatment to prevent a critical situation such as Mr Smith's arising and the District Nurses were best placed to provide this. In Mr Smith's case the referral for District Nursing input was not until a very late stage even though the GP had identified at an early appointment that compression would be of benefit.

4. The evidence before the inquest was that there were multiple specialisms across multiple GM Trusts with different IT systems involved in Mr Smith's care. As a consequence communication was poor with a limited understanding of his overall condition and fragmented input. The inquest was told that a framework that promoted a structure for a multi-disciplinary team approach across trusts in GM would avoid many of the challenges around information sharing across trusts.

5. In Mr Smith's case there had been advice from secondary care to his GP that he should be referred on the 2 Week wait path for dermatology. That advice was not taken by his GP who felt such a referral was not necessary. It was unclear what if any protocol was in place across GM when such advice was given but not followed.

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 8th May 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 [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**  **13.03.2024**