	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS ENGLAND** **2. GREATER MANCHESTER INTEGRATED CARE**
1	**CORONER** I am Adrian Farrow, Assistant 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 10th August 2023, an investigation was commenced into the death of Dr Richard George Hardman, aged 77 years. The investigation concluded at the end of the inquest on 20th March 2024. The conclusion of the inquest was that the medical cause of death was: **1a) Aspiration Pneumonia** **1b) PEG feeding** **1c) Oropharyngeal Dysphagia due to Bulbar Myopathy due to radiotherapy for Tonsillar Cancer (2001) and Parkinson's disease** The conclusion as to his death was that he died from aspiration pneumonia which arose as a result of a combination of natural disease and recognised effects of necessary medical treatment.
4	**CIRCUMSTANCES OF THE DEATH** Dr Hardman underwent radiotherapy in 2001 for tonsillar cancer and after a number of years developed dysphagia which was later found to be a late onset side effect of the cancer treatment. He was at risk of aspiration due to hypersalivation and mucus secretions, such that a PEG tube was inserted in July 2022 to mitigate the risk. He developed symptoms of and was diagnosed with Parkinson's disease by a consultant neurologist. Parkinson's disease further compromised his ability to swallow and breathe. By May 2023, his respiratory system was significantly compromised, he was under the care and supervision of the North West Ventilation Unit (NWVU). There were difficulties in identifying both the provider of a suction machine and training in the use of a suction machine at home, as he did not live within the immediate geographical area of the NWVU from which the recommendation for a suction machine came with the result that the machine was unavailable for a period of about a month. Dr Hardman then suffered a spontaneous sigmoid volvulus which was resolved as an in-patient, but without surgical intervention. On 7th August 2023, Dr Hardman became unwell and on admission to hospital, was found to have aspiration pneumonia and a partial sigmoid volvulus confirmed at post-mortem. The evidence in the inquest strongly suggested undetected gastroparesis and the post-

	mortem examination revealed evidence of chronic aspiration. There were a number of different medical disciplines involved in Dr Hardman's treatment and care across a number of different NHS hospitals, but the absence of any lead practitioner meant that there was no global oversight of the various complex interacting conditions and care and whilst the inquest did not find evidence to say, had such a lead practitioner been in place, that Dr Hardman's life would have been prolonged or saved, the potential for more collaborated, holistic care was clearly apparent which could in patients with complex multi-disciplinary needs, prevent 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 could 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 absence of any obvious mechanism for the various medical disciplines across different hospital sites to be brought together in complex medical cases under the leadership of a single practitioner in a position to evaluate and co-ordinate the best approach and combination of medical care for the patient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 14th June 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 Person: [redacted] on behalf of Dr Hardman's family. I am also sending copies to the Chief Executives of the Manchester University NHS Foundation Trust and the Stockport NHS Foundation Trust. 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	**Adrian Farrow** **HM Assistant Coroner**  **19.04.2024**