REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Rt. Hon. Victoria Atkins MP, Secretary of State for Health and Social Care

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 3rd April 2024, Alison Mutch OBE, Senior Coroner, opened an inquest into the death of John Richard Hartey who was found dead at his home on 20th October 2023, aged 57 years. The investigation concluded with an inquest which I heard on 3rd May 2024.

A post mortem examination determined the medical cause of Mr Hartey's death as being:-

1) a) Congestive cardiac failure;

b) Hypertensive heart disease;

c) Type 1 Diabetes Mellitus

II) Acute bronchitis and transplant immunosuppression

The conclusion of the inquest was a Narrative Conclusion of natural causes contributed to by recognised complications arising from transplant immunosuppression.

CIRCUMSTANCES OF THE DEATH

Mr Hartey was found dead at his home on 20th October 2023 as a consequence of congestive cardiac failure against a background of hypertensive heart disease and Type 1 Diabetes Mellitus. His death was contributed to by acute bronchitis and transplant immunosuppression.

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 **MATTER OF CONCERN** is as follows. –

The court heard evidence to the effect that in the days prior to his death, Mr Hartey's General Practitioner had made an Urgent Referral to the local District Nursing service which was received on 19th October 2023. Mr Hartey was allocated the first available appointment which was not until 23rd October 2023.

It is a matter of concern that a national shortage of District Nurses / Community Specialist Practitioners can lead to a delay in patients being seen in accordance with their needs.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **24th July 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, and to Mr Hartey's sister.

I have also sent a copy to Urmston Group Practice and Manchester University 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.

Dated: **29th May 2024**

Signature: Chris Morris, HM Area Coroner, Manchester South.