REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Greater Manchester Integrated Care Board 2) NHS England
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 30th May 2023 I commenced an investigation into the death of James Neil COCKBURN. The investigation concluded on the 29th May 2024 and the conclusion was one of Narrative: Died from a myocardial infarction whilst under the care of cardiac specialist teams for assessment for cardiac intervention. The medical cause of death was **1a) Acute myocardial infarction 1b) Coronary artery atheroma 1c) II Diabetes (type 2), Aortic Stenosis, End stage renal disease (on Dialysis), Hypertension, Obesity**
4	CIRCUMSTANCES OF THE DEATH James Neil Cockburn had multiple comorbidities. He was referred in August 2022 to cardiology after an echocardiogram indicated he had moderate to severe aortic stenosis of the aortic valve. He had a cardiology appointment on 12th December 2022 and was referred for a trans oesophageal echocardiogram in February 2023. A further echocardiogram on 23rd February at Salford Royal Hospital confirmed severe aortic stenosis that result was entered on the Manchester University Foundation Trust system on 17th March 2023. He was referred to the cardiac surgery team. He saw the cardiac surgeon on 10th May 2023. He was referred for further tests to assess for open heart surgery. Whilst awaiting these tests he had a myocardial infarction and died at his home address on 26th May 2023.
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. – The inquest heard that despite the referral being in August 2022 he had to wait months for his appointment due to the demand on cardiac services. This was significant across Greater Manchester but reflected a national picture of significant delays in patients waiting to see a cardiologist. As a consequence patient/s with cardiac issues are subject to delays in treatment plans and decision making regarding suitability for potentially lifesaving surgical procedures. In Mr Cockburn's case he died whilst waiting assessment for his suitability for open heart surgery. It was 9 months since the first referral. The position the inquest was told is exacerbated due to significant wait times for essential tests such as trans oesophageal echocardiograms to be carried out due to a shortage of suitably quailed professionals to carry them out. In his case the position was further exacerbated by delays in communication between two different trusts – NCA and MUFT. Their IT systems are completely separate and cannot transmit information into the others patient records easily. This meant that it was almost a month before the system at MUFT was updated with the test results from Salford Royal.
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 27TH August 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 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.
9	**Alison Mutch** **HM Senior Corner**  **02.07.2024**