REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1) The Secretary of State for Health and Social 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 27th December 2023 I commenced an investigation into the death of Lorraine Julia PROCTER. The investigation concluded on the 25th June 2024 and the conclusion was one of **natural causes.** The medical cause of death was **1a)** Acute myocardial ischaemia **1b)** Coronary artery atheroma **1c)** Ischaemic cardiomyopathy II, Type 2 diabetes mellitus, chronic obstructive pulmonary disease, sleep apnoea.
4	**CIRCUMSTANCES OF THE DEATH** Lorraine Julia Proctor had a history of cardiac health issues. She was discharged from hospital on 2nd March 2023 with an indication she should have a cardiology follow up appointment 3 months later. The appointment should have been in June 2023.It did not take place as the waiting list for routine cardiology appointments was 48 weeks. The inquest was told it was unlikely the appointment had it taken place would have changed the treatment she was on. On 22nd December 2023, Lorraine Julia Proctor as found unresponsive in bed at her home address [redacted]. A post-mortem established that the direct cause of her death was **1a)** Acute myocardial ischaemia **1b**) Coronary artery atheroma **1c)** Ischaemic cardiomyopathy.
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 was told that there are significant backlogs for cardiology appointments not just in Greater Manchester but nationally. The reasons the inquest was told were multi factorial and included demand, resources available, covid backlogs and the impact of strike action. As a consequence patients referred for first cardiology appointments from primary care are often waiting in excess of 40 weeks for a first specialist appointment and existing cardiology patients are also waiting similar periods of time for follow up appointments. In Ms Proctor's case the inquest was told that it was unlikely that there would have been a change to the treatment she was on even if she had been seen. However it was clear that this would not always be the case and patients requiring specialist input were not receiving it within the timescales that reduced the risk of complications and death.
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 11th September 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, Stepping Hill Hospital, 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**  **17/07/2024**