REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1)SSP Health 2) Department of 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 20th November 2023 I commenced an investigation into the death of Allan Robin Hamilton. The investigation concluded on the 16th July 2024 and the conclusion was one of Narrative: **Died from Lobar pneumonia after a request for advice from his GP practice was not actioned until 3 days after it was sent to them. The medical cause of death was 1a) Lobar Pneumonia II) Ischaemic Heart Disease**
4	**CIRCUMSTANCES OF THE DEATH** Allan Robin Hamilton sent an email to his GP practice on 14th November 2023 indicating he was having breathing difficulties and seeking advice. The email was not responded to until 17th November when he was sent an email asking if he still needed an appointment. On 19th November 2023 he was found unresponsive at his home address. A Postmortem examination found he had died as a consequence of lobar pneumonia. On the balance of probabilities, he would not have died on the day he did had he seen a doctor on 14th November 2023.
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 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 evidence that the GP practice in question is owned by SSP Health. The company owns a number of GP practices and that operate on a similar model. Like many GP practices the surgery in question had moved to a system where contact was encouraged electronically. The surgery had no system for tracking email queries such as the one sent by Mr Hamilton and there was no clear system for triage of emails such as the one he sent. The inquest heard evidence that an electronic system of patient referrals is only effective if there is a clear and robust process for checking regularly for patient contacts, a clear audit trail and effective triage by medically qualified members of the team.

	In Mr Hamilton's case effective scrutiny of his query and follow up contact from his GP on 14/11 and medical advice would probably have meant he would not have died when he did. The inquest heard evidence that there was a risk of a similar situation arising if GP practices do not have clear and robust triage and audit processes in place.
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 18th October 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**  **23/08/2024**