REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive Officer, Manchester University NHS Foundation Trust

CORONER

I am Chris Morris, Area Coroner for Greater 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 19th June 2024, Alison Mutch, Senior Coroner for Greater Manchester (South), opened an inquest into the death of Jyoti Rao, who died on 20th February 2024 at Tameside General Hospital, Ashton-under-Lyne, aged 56 years. The investigation concluded with an inquest which I heard on 16th September 2024.

The inquest determined that Miss Rao died as a consequence of:-

1) **a) Hypoxic-ischaemic brain injury;**
b) Sepsis on background of end-stage renal failure with failure of transplanted kidney.

II Traumatic nasogastric tube insertion

The conclusion of the inquest was a Narrative Conclusion, to the effect that Miss Rao died as a consequence of complications arising from renal transplantation.

CIRCUMSTANCES OF THE DEATH

Miss Rao died on the 20th February 2024 at Tameside General Hospital, Ashton-under-Lyne as a consequence of Hypoxic-ischaemic brain injury due to sepsis on the background of end-stage renal failure with failure of a transplanted kidney. Miss Rao's death was contributed to by traumatic nasogastric tube insertion.

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. –

Whilst the court heard evidence as to the advantages of the 'Consultant of the Week' model in terms of team working, it is a matter of concern that complex transplant patients such as Miss Rao are not allocated a named consultant, who not only (in conjunction with others) can seek to ensure

continuity of care is provided, but also who can take a longer-term view of the patient's post-operative course and trajectory when complications arise.

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 **20th November 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, Miss Rao's brother and sister-in-law, and the Trust's legal team.

I have also sent a copy to Tameside and Glossop Integrated Care NHS Foundation Trust, the Care Quality Commission and NHS Greater Manchester Integrated Care 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: **25th September 2024**

Signature: Chris Morris, Area Coroner, Manchester South.