REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], 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 7th June 2024, I opened an inquest into the death of John Turner who died on 23rd August 2023 at Tameside General Hospital, Ashton-under-Lyne, aged 73 years. The investigation concluded with the inquest which I heard on 27th September 2024.

A post mortem examination determined Mr Turner died as a consequence of:

1) a) Pulmonary Embolism;

1) b) Deep Vein Thrombosis.

At the end of the inquest, I recorded a conclusion of Natural Causes contributed to by Neglect.

CIRCUMSTANCES OF THE DEATH

Mr Turner died on 23rd August 2023 at Tameside General Hospital as a consequence of a Pulmonary Embolism due to a Deep Vein Thrombosis, neither of which had been identified when he previously presented at the hospital's Emergency Department on 20th August 2023.

Mr Turner first became unwell whilst on holiday in Greece and experienced a cough and following his return home, progressive breathlessness. A course of oral antibiotics prescribed by a staff member at the GP surgery did nothing to improve his symptoms, leading Mr Turner to attend the Emergency Department where he was assessed and sent home without any further treatment in circumstances where a D-Dimer test requested by the triage nurse was not undertaken

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 court heard evidence as to a wide-range of factors ranging from demographics, difficulties in accessing primary care and increasing acuity of illness in an ageing population which have combined to create great pressure on hospital Emergency Departments.

In the present case, the court heard evidence as to significant deviation (which can particularly occur at times of high demand) from the Manchester Triage System which seeks to safely manage patient flow with reference to competing needs.

In addition, it was almost 8 hours before the senior doctor who reviewed Mr Turner on 20th August 2023 recorded her findings in the electronic patient record, in all likelihood reflecting competing clinical demands on her time.

In the light of the above, I am concerned, as a practical consequence of unremitting demand on this and other Emergency Departments, the scope for identifying major or life-threatening illness which presents atypically is significantly reduced.

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 **28th 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 and [redacted] of Leigh Day & Co. on behalf of Mr Turner's family, together with [redacted]s of Weightmans LLP on behalf of the Trust.

I have also sent a copy to the Care Quality Commission, Tameside Metropolitan Borough Council, NHS Greater Manchester Integrated Care Partnership and [redacted], Member of Parliament for Ashton-under-Lyne, 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: **3rd October 2024**

Signature: Chris Morris HM Area Coroner, Manchester South.