REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health NHS England Stepping Hill Hospital
1	**CORONER** Christopher Murray HM Assistant Coroner Manchester South Coronial Area Mount Tabor Stockport
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 29th August 2023 an inquest was opened into the death of Ryan James Richard Campbell aged 33. At the inquest I concluded that Ryan Campbell died as a result of an acute myocardial infarction due to severe coronary artery atheroma that had not been identified for surgical intervention, which was likely to have resulted in survival, during medical investigation as imaging measures were still awaited at the time of his death.
4	**CIRCUMSTANCES OF THE DEATH** Ryan Campbell had been suffering with chest pain which prompted him to visit his GP on 15th December 2023. His GP referred him immediately to Stepping Hill Hospital she underwent a series of tests. He was discharged on 16th December 2023 and arrangements were made for follow up tests, namely echo cardiogram, a CT angiogram and a 24 hr heart monitor. The subsequent echocardiogram and 24hr heart monitor did not provide any further diagnostic outcome but his symptoms persisted and he consulted his GP again on 19th January 2024 resulting in a expedite letter sent the same day to the bookings team in the imaging section of the cardiology department. It was not until the 22nd February 2024 that the cardiology team requested an urgent stress

	echocardiogram which was then scheduled for 3rd April 2024
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 absence of a full suite of cardiac diagnostic imaging equipment at Stepping Hill Hospital, particularly CT or MR angiograms, contributes to delays in diagnosis for patients and the risk of delays is heightened by having to switch treatment centres. This lack of a range of equipment is inconsistent with providing a full cardiology service to patients.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and/or your organisation 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 **26th 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Ryan's family. HHJ Alexia Durran, the Chief Coroner of England & Wales The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.

9	**DATE** 1st October 2024 Signed C S Murray HM Assistant Coroner