REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Townhead Surgery**
1	**CORONER** **I am Jonathan Heath, Senior Coroner for the coroner area of North Yorkshire and York.**
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 04 June 2024 I commenced an investigation into the death of Richard James MOSS aged 72. The investigation concluded at the end of the inquest on 09 April 2025.The cause of his death was 1 a) Myocardial Infarction 1b) Coronary Artery Thrombosis. The conclusion of the inquest was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** On 15 March 2024, Richard James Moss attended his General Practitioner with intermittent chest discomfort. He was properly treated, and the intention was to refer him to the Rapid Access Chest Pain Clinic. He was found deceased on 29 May 2024. The cause of his death was 1a) Myocardial Infarction 1b) Coronary Artery Thrombosis. At the time of his death the referral had not been actioned, but it cannot be determined that the outcome for Mr Moss would have been different.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows: When a referral document is completed by a medical practitioner at this practice, an alert to colleagues to action the referral will only be sent if the practitioner manually selects the option to do so rather than every referral document completion automatically generating an alert.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 20 June 2025. 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: [redacted] (Family) (Family) [redacted] (Medical Protection) I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**25 April 2025 Jonathan Heath**