REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Central Manchester NHS Foundation Trust, Cobbett House, Manchester University NHS Foundation Trust Oxford Road, Manchester M13 9WL.
1	**CORONER** I am Andrew Bridgman, HM Assistant Coroner, for the Manchester City Area.
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 19.03.19 an investigation commenced into the death of **Norma Bradbury** who died on 03.03.19. The investigation concluded on 15.01.21. The conclusion was one of **Natural Causes contributed to by medication** The medical cause of death was **1a Intra-cerebral haemorrhage** **1b Systemic hypertension and oral anti-coagulation for atrial fibrillation**
4	**CIRCUMSTANCES OF THE DEATH** On 15.02.19 at the MRI Mrs Bradbury underwent aortic valve replacement. She was discharged to home on 22.02.19. On 03.03.19 Mrs Bradbury was found deceased at the side of her bed.
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. – Mrs Bradbury was discharged on 22.02.19. The discharge letter to her GP instructed a review within 1 week to check Mrs Bradbury's bloods and blood pressure, and to restart Losartan, and titrate the dose to her blood pressure. The consultant giving evidence at the hearing was clear that he expected this to have commenced within a week of discharge. The evidence of Mrs Bradbury's GP was that the discharge letter was not received until 25.02.19. The GP also advised that the delay in receiving discharge letters was very variable, between days and weeks.

	I accept that in many cases the discharge letter is no more than a summary of an attendance and requires little or no further action on the part of the GP and the delay is of no consequence. However, where, as here, the discharging hospital requires GP involvement within 1 week of discharge a delay of 3 days in requesting or advising that involvement is not acceptable. While it was not possible to determine any difference in outcome in Mrs Bradbury's case there is a risk that such a delay would make a difference.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to ensure that when, following discharge, a GP is expected to provide follow up care within a short and/or specific timetable the discharge letter is sent on the day of discharge to arrive that same day. 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 **Monday 29 March 2021**, 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, who may find it useful or of interest. [redacted] (on behalf of the family). 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	**Dated this 27th day of January 2021**  **Andrew Bridgman** **HM Assistant Coroner**