REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Tameside Clinical Commissioning Group.
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South.
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 16th November 2020 I commenced an investigation into the death of Brian Mottram. The investigation concluded on the 26th May 2021 and the conclusion was one of; Narrative: Died from Covid 19 pneumonitis not diagnosed until after his death contributed to by his previous necessary surgery for lung cancer caused by a combination of smoking and asbestos exposure during his working life. The medical cause of death was 1a Covid 19 Pneumonitis; II Chronic Obstructive Pulmonary Disease, Ischaemic Heart Disease, Previous Right Upper Lobe Resection for Lung Adenocarcinoma, Type 2 Diabetes Mellitus.
4	CIRCUMSTANCES OF THE DEATH On 15th November 2020, Brian Fredrick Mottram was found unresponsive at his home address, [redacted]Markham Street, Hyde. He had been feeling unwell for over a week. On 13th November 2020 he had a telephone consultation with the GP. He reported shortness of breath, a cough, a tight chest, feeling hot and cold and not eating. He was not seen face to face and he was prescribed antibiotics. Post mortem examination found that he had died from Covid 19 pneumonitis. He was at risk of complications of Covid 19 due to his underlying health issues including diabetes, chronic obstructive pulmonary disease and a previous lobectomy for lung cancer. The lung cancer was due, on the balance of probabilities, to a combination of smoking and asbestos exposure during his working life.

5	<u>CORONER'S CONCERNS</u> 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. – 1. The inquest heard that the GP surgery in common with surgeries across Tameside had a policy of predominantly using telephone appointments rather than face to face or video appointments. It was accepted at the inquest that Brian Mottram's symptoms were consistent with Covid 19 but not there was no evidence before the Court that they were considered as such by the GP. A face to face appointment and testing in such a scenario may well have led to identification of Covid 19 and different treatment. 2. It was unclear during the inquest how GPs in Tameside were identifying high risk potential Covid 19 cases or the tools that they had to assist with identifying when to bring in for additional assessment patients who were particularly vulnerable to the effect of Covid 19 to check, for example oxygen levels consistent with silent hypoxia.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and 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 6th August 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 the family of the deceased, 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.
9	Date: 11th June 2021 Signature:  Alison Mutch HM Senior Coroner