REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Right Hon. Matt Hancock MP, Secretary of State for Health and Social Care; Sir Simon Stevens, Chief Executive, NHS England.
1	CORONER I am Chris Morris, Area Coroner for 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 15th April 2020, Alison Mutch OBE, Senior Coroner for Greater Manchester South, opened an inquest into the death of Amy Hogan who died at Tameside General Hospital, Ashton under Lyne on 21st January 2020, aged 23 years. The investigation concluded at the end of the inquest, which I heard on 2nd July 2020. A post mortem examination determined Miss Hogan died as a consequence of:- **1)a) Hypoxic brain injury;** **b) Pulmonary embolism;** **c) Deep vein thrombosis** **II Oral contraceptive pill, obesity.** The inquest concluded with a narrative conclusion to the effect that **Miss Hogan died as a consequence of complications of a deep vein thrombosis. Whilst this is a natural cause of death, it is likely her death was contributed to by a recognised complication of the oral contraceptive pill.**
4	CIRCUMSTANCES OF THE DEATH From around September 2019, Miss Hogan began to report sporadic and non-specific symptoms of feeling unwell. Having initially attended the Pennine Medical Centre in Mossley as a visiting patient, Miss Hogan registered with that practice. Miss Hogan received treatment from doctors

	at the practice for depression and anxiety, and continued to be prescribed the oral contraceptive pill following a risk assessment by the practice pharmacist. On 20th January 2020, Miss Hogan attended the out of hours doctor at Oldham Primary Care hub, reporting a 3 day history of feeling light-headed, weak and drained. Whilst Miss Hogan had told others she had experienced breathlessness and leg pain, this information was not conveyed to the out of hours doctor. Whilst Miss Hogan disclosed to the doctor details of the anti-depressant medication she had been prescribed, he was not informed she was taking the oral contraceptive pill. The following day, Miss Hogan became acutely unwell and collapsed at her home. She was taken to hospital by ambulance where she died.
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. – 1) The inquest heard evidence from Miss Hogan's regular GP that, despite being requested, the General Practice records from her previous practice never arrived. It is a matter of concern that delayed, incomplete or non-existent transfer of patient data from one practice to another on moving places an unfair burden on patients to accurately recall and relay their own medical histories. It is a matter of particular concern that such issues create particular problems for vulnerable patients, who simply may not be in a position to do so; 2) Notwithstanding numerous previous initiatives as to information-sharing and digitisation of patient data, it is a matter of concern that the out of hours GP reviewing Miss Hogan had no electronic access to her regular GP records. Access to such records would have revealed, amongst other things, Miss Hogan was prescribed the oral contraceptive pill, which is likely to have led the doctor to ask additional questions about her symptoms. Again, it is a matter of particular concern that an inability to access regular GP records in the out of hours setting raises additional risks for vulnerable patients.
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 25th September 2020. 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 Miss Hogan's parents. I have also sent a copy of my report to Dr [redacted] and Dr [redacted] who may find it useful or of interest. I have also sent it to Tameside CCG. 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	**Christopher Morris** **HM Area Coroner, Manchester South** **31.07.2020**