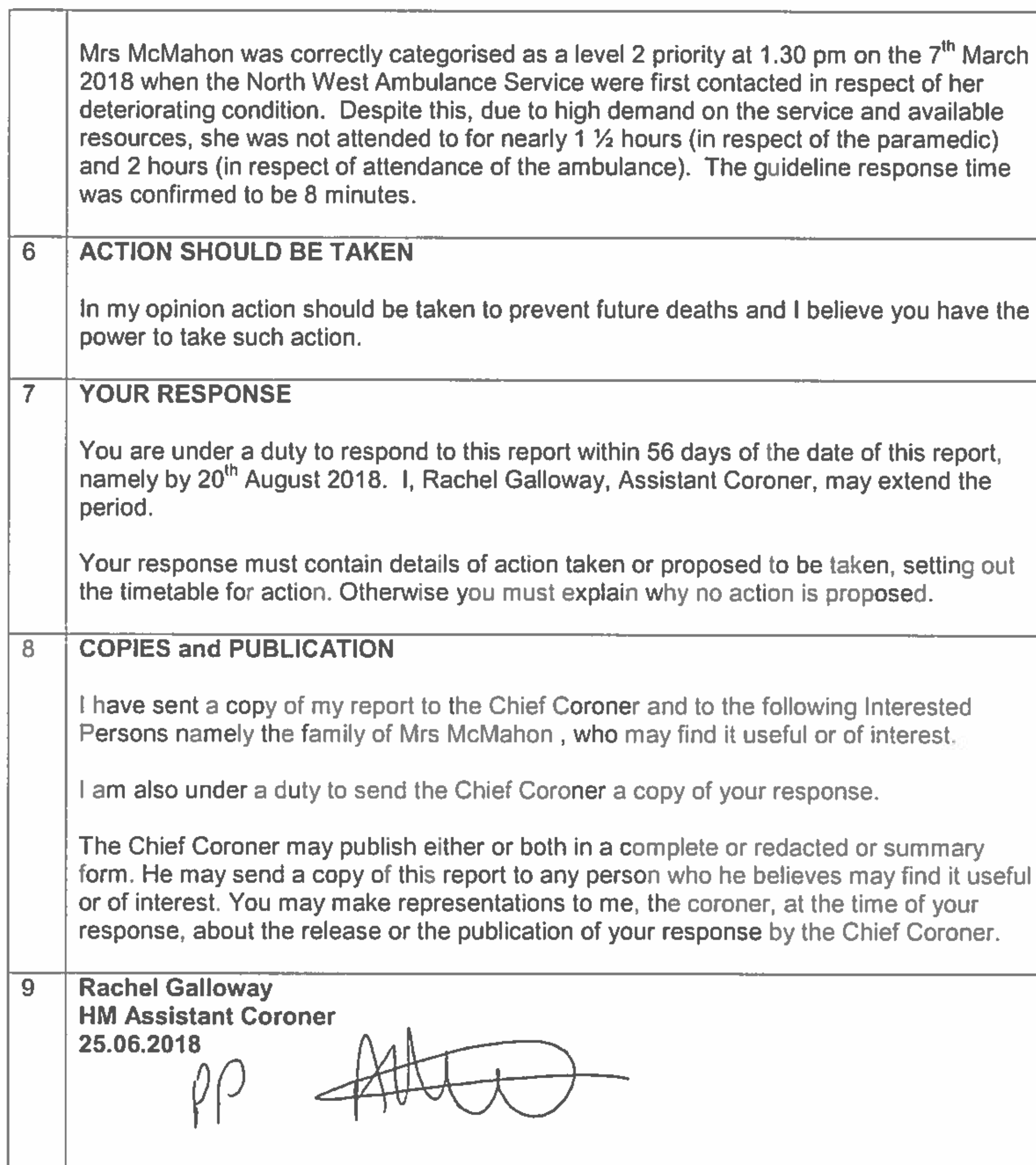
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Department of Health NHS England
1	**CORONER** I am Rachel Galloway, Assistant Coroner, for the coroner area of South Manchester.
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 the 26th March 2018 an inquest was opened into the death of Marjorie McMahon. The evidence was heard at inquest on the 21st June 2018 and my conclusions were given on the same date. The conclusion left was: Natural Causes. The medical cause of death was: 1a Community acquired pneumonia II Dementia
4	**CIRCUMSTANCES OF THE DEATH** On the 3th March 2018 Mrs McMahon was noted to be chesty by a staff member at Cherry Tree House. Her condition did not cause staff concern until the morning of the 7th March 2018 when attempts were made to contact her GP without success. At 1.30 pm on the 7th March 2018 an ambulance was called after staff contacted "111" for advice regarding Mrs McMahon's deteriorating condition. Due to heavy demand on the service, a paramedic was unable to attend until 2.58 pm. The paramedic provided oxygen and fluid treatment to Mrs McMahon and an ambulance subsequently arrived at 3.30 pm to convey her to A&E at Stepping Hill Hospital. On arrival at hospital she was assessed and commenced on intravenous antibiotics. Despite treatment, her condition continued to decline and she passed away on the 8/3/2018.
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 McMahon was correctly categorised as a level 2 priority at 1.30 pm on the 7th March 2018 when the North West Ambulance Service were first contacted in respect of her deteriorating condition. Despite this, due to high demand on the service and available resources, she was not attended to for nearly 1 ½ hours (in respect of the paramedic) and 2 hours (in respect of attendance of the ambulance). The guideline response time was confirmed to be 8 minutes.
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 20th August 2018. I, Rachel Galloway, Assistant 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 Mrs McMahon , 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	**Rachel Galloway** **HM Assistant Coroner** **25.06.2018** pp