REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Sir David Dalton, Chief Executive Pennine Acute Hospital NHS Trust
1	**CORONER** I am Catherine McKenna, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 26 October 2018 I commenced an investigation into the death of **Marjorie GARTSIDE** aged 100. The inquest concluded on 11 March 2019. The medical cause of death was: 1a Advanced frailty of age 2 Left fractured neck of femur (operated on), Type 2 diabetes mellitus, atrial fibrillation. The Coroner's conclusion was: Natural causes to which an injury sustained as a result of an unwitnessed fall contributed.
4	**CIRCUMSTANCES OF DEATH** Marjorie Gartside, aged 100, was a resident at the Stoneswood Residential Home in Delph, Oldham (the Home). On 25 September 2018, Mrs Gartside fractured her hip as a result of an unwitnessed fall at the Home. She had pre-existing atrial fibrillation, diabetes and at the time of the fall was suffering from shingles. Mrs Gartside was taken to the Royal Oldham Hospital and surgery to repair the fracture took place on 29 September 2018. Her post-operative care was provided on ward T7, the orthopaedic ward. On 10 October 2018, the Royal Oldham Hospital contacted the Registered Manager of the Home to inform them that Mrs Gartside was ready for discharge and was mobilising with assistance. The Registered Manager of the Home was subsequently informed by a friend of Mrs Gartside who regularly visited at the Hospital that Mrs Gartside was not mobilising and was still very poorly. As a result of this conversation, the Registered Manager contacted the Hospital and asked that discharge been postponed until a profiling bed and appropriate mattress was put in place. On 12 October 2018, Mrs Gartside was discharged from Ward T7 to the Home. On her arrival at the Home, the Registered Manager contacted the GP as she was concerned that Mrs Gartside appeared unresponsive. The GP attended and found Mrs Gartside to have hypoglaecaemia of 2.7, tachycardic and hypotensive. There had been no handover of care to the Home and it was unclear to both the Home and the GP as to whether plans for palliative care had been put in place by the Hospital. Given that the conditions which Mrs Gartside presented with were all reversible, she was transferred back to the Royal Oldham Hospital on the same day and admitted under the medical team. On re-admission to the Royal Oldham Hospital, Mrs Gartside was noted to have low blood sugars and acute kidney injury secondary to dehydration. She was re-hydrated and responded to treatment for low blood sugar. On 15 October, an End of Life Care Plan was put in place and Mrs Gartside was discharged back to the Home on 17 October. The anticipatory medications which had been prescribed for Mrs Gartside were not sent with her when she returned to the Home.

	Mrs Gartside died at the Home on 19 October 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:- 1. That the information provided by the Royal Oldham Hospital to the Home on 10 October 2018 was inaccurate in suggesting that Mrs Gartside was able to mobilise. Had that information been relied upon by the Home it would have resulted in Mrs Gartside not having suitable or appropriate equipment in place for her return. 2. That Mrs Gartside's discharge from the Royal Oldham Hospital on 12 October 2018 appears to have been unsafe and raises a concern about the robustness of discharge processes. 3. There appears to have been no handover of care and a lack of clarity as to whether Mrs Gartside was for palliative care when she was discharged from the Royal Oldham Hospital on 12 October 2018. 4. That the prescribed anticipatory medication was not sent with Mrs Gartside when she was discharged on 17 October 2018.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **7 May 2019**. I, the Area 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:- [redacted] (daughter of the Deceased) Saddleworth Medical Practice, Uppermill OL3 6AH [redacted] Registered Manager of Stoneswood Residential Home, Delph OL3 5EB 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 from. He may send a copy of this report to any person who he believes may find it usefulor 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: 12 March 2019 Signed: [signature]