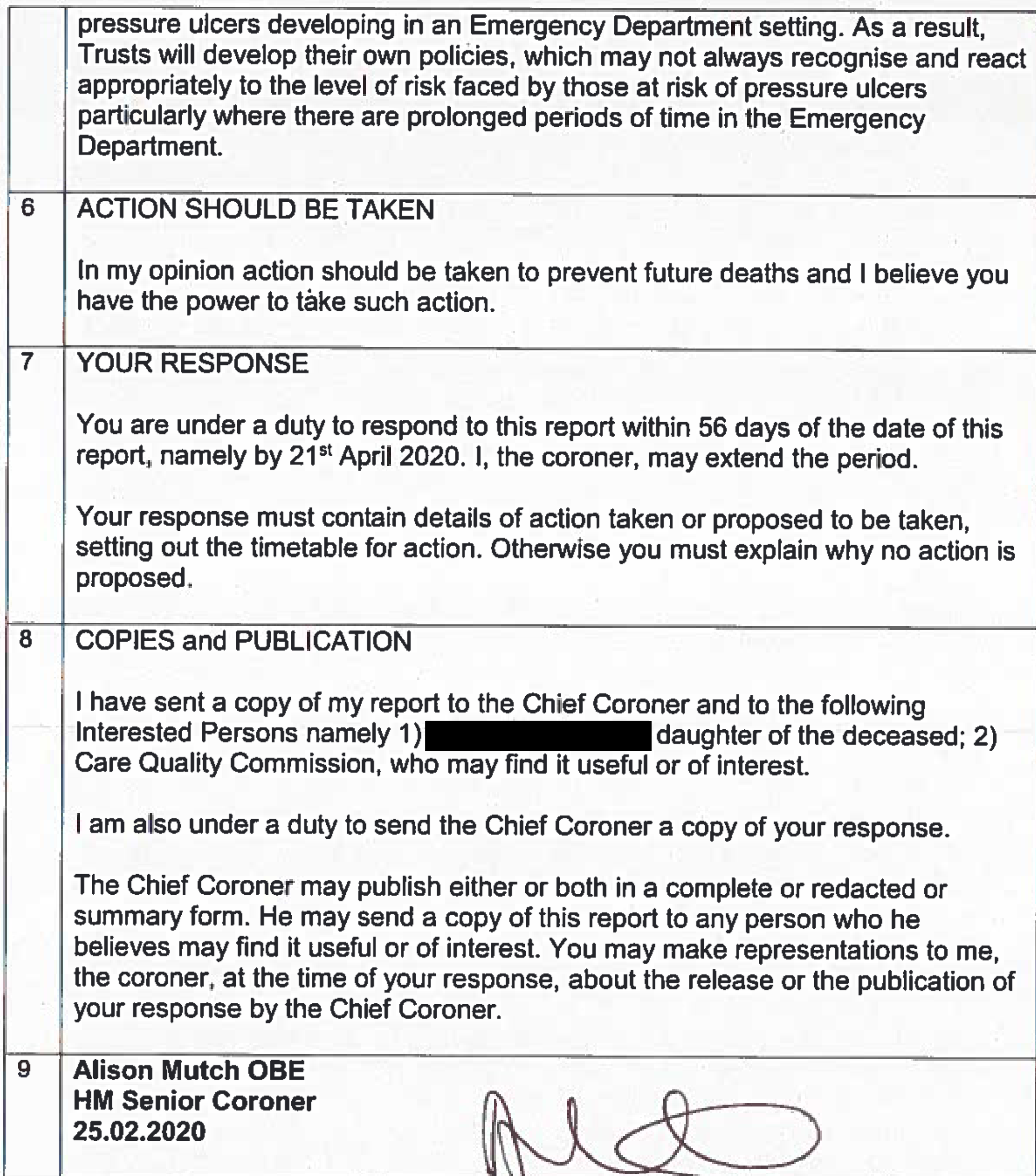
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **The Secretary of State and the Chief Executive of the National Institute for Health and Care Excellence (NICE).**
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 10th July 2019, I commenced an investigation into the death of Beryl Holland. The investigation concluded on the 9th January 2020 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a) Hospital acquired pneumonia; 1b) Neck of femur fracture; 1c) Fall; II) Myocardial infarction; type 1 diabetes, pressure ulcers, dementia.**
4	CIRCUMSTANCES OF THE DEATH Beryl Holland sustained a fractured neck of femur at the care home where she resided after a fall. She had poor skin integrity and was high risk in relation to pressure ulcers. She was admitted, via the Emergency Department, to Stepping Hill Hospital and operated on. Post operatively she continued to decline. She died at Stepping Hill Hospital on 7th July 2019.
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. – The inquest heard that Beryl Holland was in the Emergency Department of the Acute Hospital for a significant period of time before ultimately been transferred to a ward. This was due to awaiting a suitable bed. She was vulnerable and at high risk of developing pressure ulcers. The trust in question had identified gaps in its processes and taken steps to reduce the risk of pressure ulcers developing/worsening in the Emergency Department. The inquest was told that there is no national guidance relating to the management of/reducing the risks of



	pressure ulcers developing in an Emergency Department setting. As a result, Trusts will develop their own policies, which may not always recognise and react appropriately to the level of risk faced by those at risk of pressure ulcers particularly where there are prolonged periods of time in the Emergency Department.
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 21st April 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 the following Interested Persons namely 1) daughter of the deceased; 2) Care Quality Commission, 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	**Alison Mutch OBE** **HM Senior Coroner** **25.02.2020**