	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care
1	**CORONER** I am Hassan Shah, Assistant Coroner for the coroner area of Northampton.
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 15/03/2018 I commenced an investigation into the death of Mr Mohan Acharya. The investigation concluded at the end of an inquest on 27/02/2020. The medical cause of death was 1A) Bilateral confluent bronchopneumonia 2) Acute renal failure. The narrative conclusion is detailed in section (4) below.
4	**CIRCUMSTANCES OF THE DEATH** Mr Mohan Acharya died on 8th March 2018 at Northampton General Hospital as a result of bronchopneumonia causing sepsis/infection which led to hypovolemia which precipitated a cardiac arrest. Although bronchopneumonia or respiratory sepsis could not be excluded, Mr Acharya presented with none of the usual features and a reasonable clinician would not have diagnosed it. It was reasonable to focus on the potential cardiac problem on the basis of the clinical presentation. The hospital was under extreme pressure and was in an Opel 4 status; there were also a number of service failings. However, these factors did not more than minimally contribute to the death either singularly or in combination.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – According to the Royal College of Emergency Medicine:- 1. Emergency department crowding is associated with increased mortality amongst admitted patients; and 2. Approximately 500 deaths per year are caused by overcrowded Emergency Departments.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation, 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 **Friday 24th 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:-. [redacted] **(Son).** **Northampton General Hospital NHS Trust** Similarly, you are 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.
9	*H Shah* – ***Mr H Shah – Assistant Coroner, Northamptonshire*** **27th February 2020**