REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Public Health England and NHS England
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 26th May 2020 I commenced an investigation into the death of Leslie Harris. The investigation concluded on the 23rd November 2020 and the conclusion was one of Narrative: Died from Covid 19 pneumonia, acquired whilst an inpatient at Stepping Hill Hospital, contributed to by the complications of an accidental fall. The medical cause of death was 1a) Covid 19 pneumonia II) Right sided neck of femur fracture, Hypertension, Atrial fibrillation
4	CIRCUMSTANCES OF THE DEATH Leslie Harris was admitted to Stepping Hill Hospital following an accidental fall at his home address. He underwent surgery for a fractured hip. Post operatively, he was unwell with a chest infection. He began to recover and was considered fit for discharge to the Cavendish unit. Whilst an inpatient, he was moved to another ward, and then moved back as the outlier ward was not felt to be appropriate for his needs. On his return, he was put on a bay where patients had been exposed to a Covid 19 positive patient. He subsequently tested positive for Covid 19. He deteriorated rapidly and died at Stepping Hill Hospital on 21st May 2020.
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 he was moved to a ward where other patients were in isolation from Covid due to the interpretation of Public Health England guidance about management in these circumstances. As a result of reflection and concerns about interpreting the guidance in this way the trust have changed their policy and such movement no longer takes place. However, the guidance from PHE has not been amended and it was unknown how other trusts were choosing to interpret the guidance and as such putting potentially vulnerable patients at risk of developing Covid 19 whilst an in-patient.
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 Wednesday 3rd February 2021. 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 [redacted] the daughter of the deceased, 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 HM Senior Coroner for Manchester South 9th December 2020