REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **Greater Manchester Health & Social Care Partnership, 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 7th September 2020 I commenced an investigation into the death of Alfred Jones. The investigation concluded on the 24th March 2021 and the conclusion was one of narrative: Died from a combination of Covid-19 and pneumonia contracted whilst an inpatient at Tameside General Hospital and exacerbated by the complications of an accidental fall at home and a further fall whilst an inpatient at Tameside General Hospital. The medical cause of death was 1a) Bronchopneumonia in combination with Covid-19; II) Falls with vertebral fractures, Type 2 diabetes mellitus, pulmonary fibrosis, heart failure and epilepsy.
4	CIRCUMSTANCES OF THE DEATH Alfred Jones had an accidental fall at home. He was admitted to Tameside General Hospital. He had a fracture at L3. He was in significant pain and had limited mobility. Whilst awaiting further investigation he had a fall on the ward resulting in fractures at L1 and L5. Whilst being medically optimised for discharge he tested positive for Covid-19 acquired in hospital. He was initially asymptomatic but began to deteriorate rapidly, on 6th September 2020. On 7th September 2020 he died at Tameside General Hospital.
5	<u>CORONER'S CONCERNS</u>

	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. The inquest heard that his stay in hospital was prolonged due to a shortage of availability of slots for the MRI scanner. This the inquest was told is due to a shortage of MRI scanners both in the Trust and the wider NHS. This was compounded by a shortage of radiology staff which the inquest was told is part of a wider issue of a national shortage of qualified radiologists and radiographers. This led to a prolonged admission in hospital whilst awaiting tests and led to him having a fall whilst on the ward and contracting Covid-19 whilst an inpatient.
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 23rd June 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] (family of 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	**24th April 2021**

	Signature:  **Alison Mutch, HM Senior Coroner, Manchester South**