REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. CHIEF EXECUTIVE STOCKPORT NHS FOUNDATION TRUST**
1	**CORONER** I am Lauren Costello, assistant coroner, for the coroner area of 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 October 2020 I commenced an investigation into the death of LESLEY MAWBY then aged 73 years. The investigation concluded at the end of the inquest on 21st May 2021. The narrative conclusion of the inquest was as follows: Lesley Mawby died as a consequence of a recognised complication of chemotherapy treatment on a background of frailty due to malnutrition where there was a delay in commencing TPN Feeding. The medical cause of death being 1a Multi-Organ Failure 1b Chemotherapy-Induced Bowel Toxicity 1c Multiple Myeloma II Upper Gastrointestinal Haemorrhage, Gastritis, Sepsis

4	**CIRCUMSTANCES OF THE DEATH** Lesley Mawby suffered from myeloma. She was diagnosed with asymptomatic myeloma at the end of 2018. She remained symptom free until around April 2020 when she started experiencing back pain. Following an MRI scan in July 2020 the decision was made to start treating her Myeloma. She was treated with Lenalidomide and Dexamethasone and began her first cycle of treatment in August 2020. On 19th August 2020 she began to experience violent diarrhoea and vomiting and was admitted to Stepping Hill Hospital for treatment. The vomiting and diarrhoea continued due to drug induced bowel toxicity. She was unable to eat any food and her electrolytes became deranged. She was referred to the dietetics department, but the assessment was delayed by a miscalculation of the MUST Score and there were further delays in assessment by the dieticians due to staffing levels. She was reviewed by a dietician on 1st September 2020 and nasogastric feeding was started along with peripheral TPN on 2nd September 2020. Full TPN was started on 4th September 2020. Lesley had lost a significant amount of weight by this stage. Lesley had an atypical response to TPN and it was not possible to bring Lesley's electrolytes and nutrition under control despite TPN and electrolyte replacement. In addition, she suffered from sepsis, upper gastrointestinal hemorrhage and she continued to deteriorate. She died on 5th October 2020 at Stepping Hill Hospital, Popular Grove, Hazel Grove Stockport of multi organ failure as a result of chemotherapy induced bowel toxicity which was caused by necessary treatment for multiple myeloma.
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. – (1) It is a matter of concern that there are residual staffing shortages in the dietetic team leading to delays in assessments on weekdays and meaning weekend cover cannot be provided.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 13th August 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 [redacted] I am also copying this report to Stockport Clinical Commissioning Group and the Care Quality Commission who I believe may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. 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	**DATE** **SIGNED BY CORONER** L. Costello **18th June 2021**