REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, National Institute for Health and Care Excellence.
1	CORONER I am Chris Morris, Area Coroner for 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 26th March 2021, Christopher Murray, Assistant Coroner, opened an inquest into the death of Maureen Johnson who died on 13th March 2021 at Stepping Hill Hospital, Stockport, aged 85 years. The investigation concluded at the end of the inquest which I heard on 1st September 2021. A doctor treating Mrs Johnson confirmed that she had died as a result of: 1.a) Acute Renal Failure; due to 1.b) Dehydration; 1.c) Gastroenteritis II Hypertension. By way of conclusion, I recorded that Mrs Johnson died as a consequence of Natural Causes.
4	CIRCUMSTANCES OF THE DEATH Mrs Johnson was ordinarily a fit and active person who lived independently in her own home. Towards the end of February 2021, Mrs Johnson became unwell with diarrhoea, vomiting and abdominal pain. After around a week, Mrs Johnson's symptoms had resolved, however returned again a number of days later. Mrs Johnson sought medical advice. In the two days prior to her death,

	two separate General Practitioners held telephone consultations with Mrs Johnson and formed the impression (albeit without examining her) that she had been suffering from a stomach bug which was resolving. On 13th March 2021, Mrs Johnson's son (who had been in regular contact with his mother throughout) spoke to her on the telephone and was concerned she sounded short of breath. On attending her home, Mr Johnson found his mother to be seriously ill. An ambulance was called, and Mrs Johnson was taken to Stepping Hill Hospital where it was quickly recognised she had developed metabolic acidosis and was gravely ill. Despite attempts to provide emergency treatment, Mrs Johnson died later that afternoon.
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. – Given their physiological susceptibility to dehydration and its effects, it is a matter of concern that authoritative guidance does not currently exist as to the assessment of diarrhoea and vomiting suspected to be caused by gastroenteritis in the over 70s, as has previously been published in respect of children and infants younger than 5. Such guidance might usefully provide a comprehensive overview of symptoms and signs of clinical dehydration in the over 70s, and give clinicians advice as to the circumstances in which a face-to-face assessment is recommended.
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 2st November 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 [redacted] on behalf of Mrs Johnson's family and to Dr [redacted] and [redacted] of RPC (Solicitors to Mastercall) as the other Interested Persons to the Inquest. I have also sent a copy of my report to the CQC and Stockport CCG 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	**Dated: 7th September 2021**  **Signature:** **Chris Morris HM Area Coroner, Manchester South.**