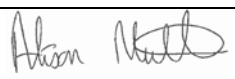
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Stockport NHS Trust
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 6th January 2021 I commenced an investigation into the death of Alan Harry Hunter. The investigation concluded on the 13th September 2021 and the conclusion was one of narrative: Died from frailty contributed to by rapid weight loss in hospital when his BMI was not correctly calculated and the relevant NICE guidance was not adhered to, exacerbated by repeated urinary tract infections. The medical cause of death was 1a Frailty; II Covid-19, Urinary Tract Infection on a background of catheterisation
4	CIRCUMSTANCES OF THE DEATH Alan Harry Hunter was admitted to Stepping Hill Hospital following a fall at Bramhall Manor. On admission he had a urinary tract infection and had periods of confusion and delirium. His BMI was not correctly calculated on admission and his MUST score was not correctly calculated. During his admission to Stepping Hill Hospital the NICE guidance on measuring weight was not followed. He lost 7kgs in weight taking his BMI to 15. He became increasingly frail. Whilst an inpatient he contracted Covid 19 on the balance of probabilities from another patient. At the time regular swabbing of patients was being undertaken but results were taking approximately 48 hours to be received by the hospital. Alan Hunter was discharged to Fernlea Care Home. His BMI was 15 and he was very frail and lethargic. He developed a further urinary tract infection. He continued to deteriorate and died at Fernlea Care Home on 30th December 2020.

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. – The inquest heard that the quality of the documentation relating to Mr Hunter was poor particularly in relation to monitoring his diet and weight. The BMI was incorrectly calculated on admission and this was not identified subsequently. As a consequence his MUST score was inaccurate and his level of risk due to his weight and poor nutritional status was not correctly understood. The NICE guidance relating to monitoring weight was not followed and this was not recognised by ward managers.
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 20/21/2021. 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 Stockport NHS Trust and the family, 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 HM Coroner's Office Manchester South