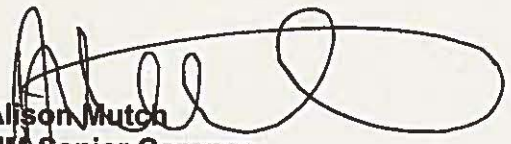
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) The Secretary of State for Health and Social Care; 2) Greater Manchester Health & Social Care Partnership, and 3) The Healthcare Safety Investigation Branch.
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 27th January 2020, I commenced an investigation into the death of Joseph Michael Cheetham. The investigation concluded on the 22nd September 2020 and the conclusion was one of **Narrative: Died from natural causes contributed to by the recognised complications of risk feeding and a previous necessary surgical procedure following an accidental fall.** The medical cause of death was **1a) Hospital acquired pneumonia; 1b) Reduced mobility on a background of left total hip replacement dislocation; II) Vascular dementia, Paroxysmal atrial fibrillation, Aspiration pneumonia.**
4	CIRCUMSTANCES OF THE DEATH Joseph Michael Cheetham had an unwitnessed accidental fall and dislocated his prosthetic hip. He underwent surgery at Stepping Hill Hospital for this. He had reduced cognitive function from dementia. He returned home on 24th December to be cared for by his family as a care package had not been put in place. On 27th December he had deteriorated and attended Stepping Hill Hospital Emergency Department. He was admitted on 28th December after being in the Emergency Department for over 24 hours. He was subsequently moved to ward A11. On 3rd January a SALT assessment identified he had severe dysphagia and was at high risk of aspiration. Guidance was given regarding reducing risk. Subsequently treatment was given for pneumonia and suspected heart failure. On 17th January he continued to require high levels of oxygen support and following a discussion with his family he was placed on end of life care. He deteriorated and died at Stepping Hill Hospital on 22nd January 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. – 1. The inquest heard that his GP had sought to have him admitted directly into hospital having identified that he needed to be hospitalised. However, contact with the trust identified that the acute bed shortage meant that this would not be possible, and he would have to go via A and E. On arrival at A and E the volume of those waiting to be seen meant that he waited in cold and draughty areas of the department. Lack of bed capacity in the hospital meant that he spent over 24 hours in the A and E department despite being frail and vulnerable. 2. The inquest heard that he was medically optimised, and he had lost weight in hospital whilst awaiting a care package to be put in place. One was still not in place by 24th December and it was likely to be at least another 2-3 weeks before one was in place. To avoid further deconditioning and weight loss in an acute setting whilst awaiting a care package his family took on caring for him at home to facilitate a discharge.
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 25th November 2020. 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], wife 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** **30.09.2020**