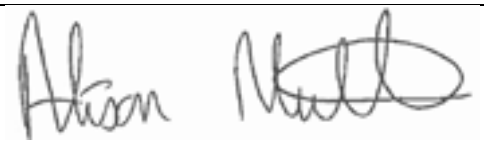
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health, Greater Manchester Health and Social Care Partnership
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 22nd October 2019 I commenced an investigation into the death of Samuel Garner. The investigation concluded on the 15th July 2020 and the conclusion was one of **Narrative: Died from the complications of injuries sustained in an accidental fall, where the injuries were not identified until three days after the fall.** The medical cause of death was **1a) Bronchopneumonia; 1b) Traumatic pneumohaemothorax; 1c) Right rib fracture; and II) Vascular dementia, Frailty**
4	CIRCUMSTANCES OF THE DEATH Samuel Garner had an accidental fall on 8th October 2019 at the nursing home where he was receiving respite care. On 11th October, he became very unwell and was admitted to Stepping Hill Hospital where rib fractures including a flail segment and a traumatic pneumothorax caused on the balance of probabilities by the fall on 8th October were diagnosed. His chest was drained but he continued to deteriorate and died at Stepping Hill Hospital on 19th October 2019.
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 evidence that on admission to Stepping Hill Hospital the Emergency Department was extremely busy due to the volume of patients in the department. This had been typical of the picture in both the preceding and following weeks due to winter pressures/demands. 2. As a result of the lack of appropriate space Mr Garner an elderly and vulnerable patient was treated in the corridor for periods during his stay in the ED. This included whilst he was being given antibiotics intravenously - he scored on the sepsis pathway on arrival. He was also moved in and out of bays depending on varying prioritisation of need. 3. He waited a number of hours for his chest to be drained (after it was identified that was what was required) due to competing demands on clinical staff. He was in significant distress whilst waiting. 4. It was identified at an early stage that he would need a surgical bed and his care would be optimised in such a setting. There was a significant delay in moving him from the Emergency Department to a surgical ward due to lack of bed capacity within the Trust.
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 21st September 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 Mrs [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 OBE** **HM Senior Coroner** **27.07.2020**