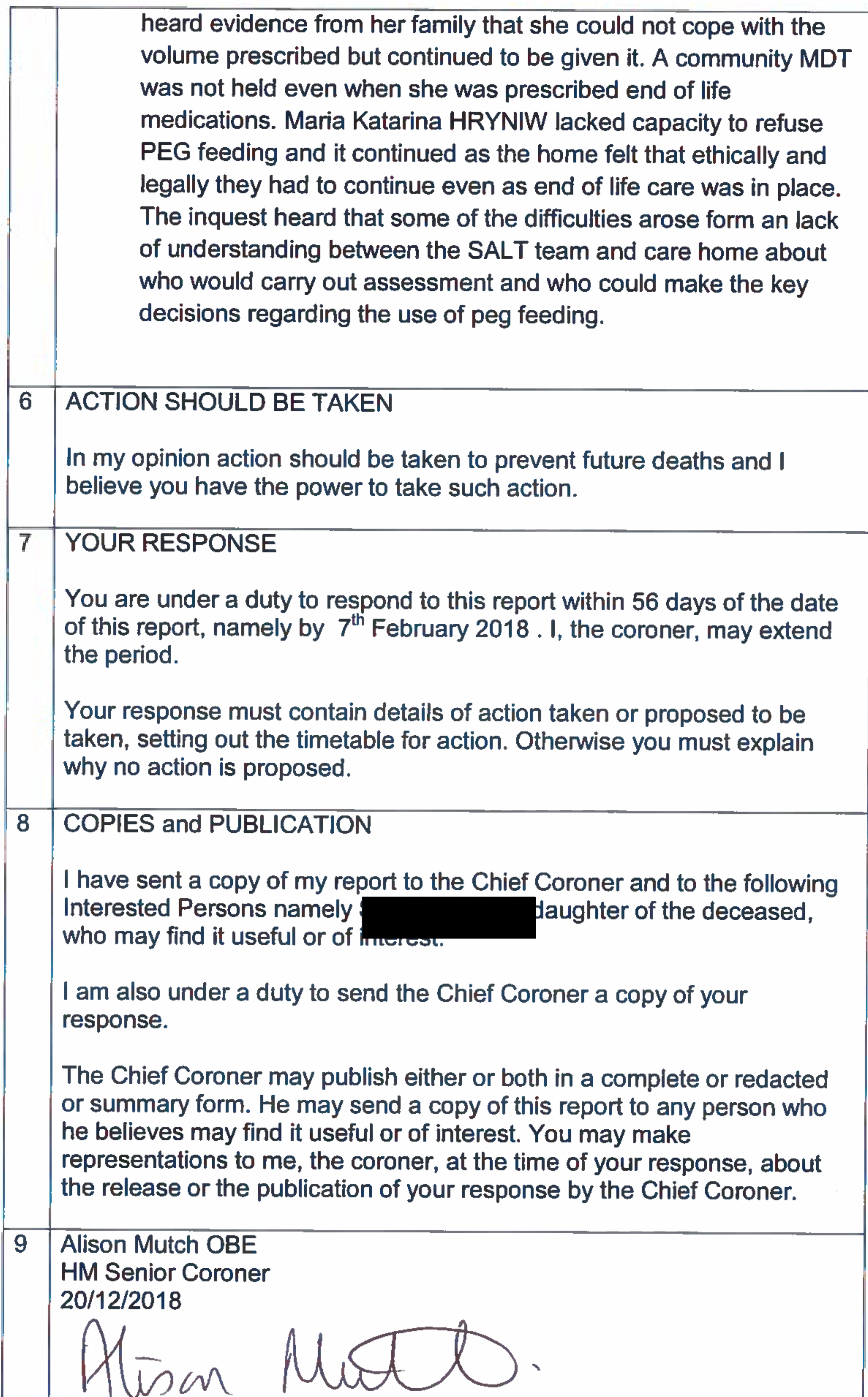
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health and the Chief Executive of Care Quality Commission
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 19th April 2018 I commenced an investigation into the death of Maria Katarina HRYNIW. The investigation concluded on the 2nd November 2018 and the conclusion was one of Natural Causes
4	CIRCUMSTANCES OF THE DEATH Maria Katarina Hryniw was PEG fed following a stroke in 2015. Following an admission to Tameside General Hospital she was discharged to The Lakes Care centre. Her mobility was very limited and a hoist was required. She developed bronchopneumonia and died at The Lakes on 14th April 2018.
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. – The inquest heard evidence that Maria Katarina HRYNIW was peg fed. She was approaching the end of life but there was no assessment regarding the suitability of the use of continued peg feeding in the community or the volume given to her. The inquest



heard evidence from her family that she could not cope with the volume prescribed but continued to be given it. A community MDT was not held even when she was prescribed end of life medications. Maria Katarina HRYNIW lacked capacity to refuse PEG feeding and it continued as the home felt that ethically and legally they had to continue even as end of life care was in place. The inquest heard that some of the difficulties arose form an lack of understanding between the SALT team and care home about who would carry out assessment and who could make the key decisions regarding the use of peg feeding.

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 7th February 2018 . 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] daughter 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
20/12/2018