REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of Manchester University NHS Foundation 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 5th March 2019 I commenced an investigation into the death of Mary Jones. The investigation concluded on the 23rd August 2019 and the conclusion was one of **Narrative: Died from the recognised complications of an accidental fall in combination with underlying frailty.** The medical cause of death was **1a) Hospital acquired pneumonia on a background of congestive cardiac failure and acute kidney injury ; 2) Left fractured neck of femur (operated on), Frailty**
4	CIRCUMSTANCES OF THE DEATH Mary Jones had an accidental unwitnessed fall. She was admitted to the Manchester Royal Infirmary (MRI) where she was operated on. She was transferred to Trafford General Hospital for rehabilitation. She was increasingly confused post-admission, probably due to dehydration and pain. On 3rd March 2019 she deteriorated rapidly having acquired an acute pneumonia on a background of congestive heart failure and acute kidney injury which in combination led to her death on 3rd March 2019 at Trafford General Hospital.
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. Mary Jones was a frail elderly lady who was moved from the MRI to Trafford General post-operatively for rehabilitation under the Trust structure. It was a planned transfer. However due to limited transport availability she arrived at Trafford General out of hours after waiting for transfer. As a result she was clerked in and risk assessed out of hours despite the recognised risks of moving frail elderly patients out of hours. The inquest was told that this is not uncommon as transfers such as these are made via ambulance and are low priority and moved where needed; 2. The falls risk assessment was completed outside the Trust target time primarily as a result of the late arrival; 3. The documentation within the nursing notes, particularly the fluid charts was poor quality, making it difficult to understand what had happened in relation to the hydration of Mrs Jones; 4. The documentation issue was exacerbated by the Trust IT merger having resulted in the loss of a number of key documents. It was unclear how the Trust were managing the risks around lost medical records where the IT merger was at the root of the issue; 5. Despite her frailty there was no evidence available at the inquest of a referral to a dietician/nutritionist. There was to have been a referral to SALT in February but no trace could be found of the referral; 6. There was no evidence of clear clinical review of the outcome of the fluid charts.
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 2019. 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 1 [redacted] on behalf of the family and; 2) Trafford Clinical Commissioning Group, 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** **30.09.2019**