REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of Manchester University Foundation Trust (MFT); The Secretary of State for Health
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 25th September 2019 I commenced an investigation into the death of Evelyn Ross. The investigation concluded on the 13th March 2020 and the conclusion was one of **Narrative: Died from complications of surgery for an acute on chronic subdural haematoma contributed to by the complications of a fractured neck of femur and anticoagulation therapy.** . The medical cause of death was **1a) Hospital acquired pneumonia on a background of a recent burr hole surgery for an acute on chronic subdural haematoma; II) Fall with fractured neck of femur, ischaemic heart disease, cerebrovascular accidents, hypertension, anticoagulation therapy.**
4	CIRCUMSTANCES OF THE DEATH Evelyn Ross fell and fractured her hip. She was operated on at Wythenshawe Hospital. Post operatively she appeared to be making a good recovery. She was transferred to Trafford General Hospital for rehabilitation. She was medically optimised by 3rd June but not discharged as arrangements were not in place for care at home. On 1st July 2019 she fell in the toilet. Two CT scans did not show any bleeds. Subsequently she began to show signs of increased confusion. On 2nd August they were attributed to a urinary tract infection and she was treated with antibiotics. The blood results did not suggest an infection. On

	8th August a CT scan was requested. It took place on 13th August. An acute on chronic subdural haematoma was identified. Anticoagulation was stopped. On 14th August she was transferred to Salford Royal Hospital where burr hole surgery was subsequently carried out. On 7th September 2019 she was transferred back to Trafford General Hospital. She continued to deteriorate with a hospital acquired pneumonia. She died at Trafford General Hospital on 23rd September 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 was told that the ward in question had been short staffed for a number of months. As a result there was a reliance on agency staff and less experienced staff. The trust was now seeking to resolve the issue but it was still not fully resolved. It reflected a wider issue of a national shortage of nurses. 2. The inquest was told that whilst Mrs Ross was medically fit for discharge prior to 1st July she had not been discharged because of delays in arranging a suitable care package to support her in the community. 3. During the course of the inquest the documentation relied on by the trust was lacking in detail and meant that it was difficult to understand her condition at key points or to understand the rationale for decisions. 4. The inquest heard that the Trust had not followed their own falls risk policy in relation to Mrs Ross. 5. There did not appear to be a clear system of regular orthogeriatric consultant reviews of Mrs Ross. This meant that there was no escalation of her condition to a consultant when she began to show signs of deterioration.
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 22nd June 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], son 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** **27.04.2020**