REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Greater Manchester Health & Social Care Partnership; 2) 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 15th June 2020 I commenced an investigation into the death of Joan Sanderson. The investigation concluded on the 4th September 2020 and the conclusion was one of **Narrative: Died from complications of a surgical procedure following an accidental fall.** **The medical cause of death was 1a) Cardio pulmonary arrest; 1b) MRSA positive left hip metalwork infection; II) Dementia, Diabetes mellitus**
4	CIRCUMSTANCES OF THE DEATH Joan Margaret Sanderson had an accidental fall. She was admitted to Tameside General Hospital where a displaced intertrochanteric fracture of the left hip was diagnosed. She was operated on. She developed an infection which was identified as MRSA. She deteriorated and died on 15th June 2020 at Tameside General Hospital.
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 from the Trust that following her death they had carried out a RCA to understand what learning could be taken from Mrs Sanderson's death. A key piece of learning was identified, as patients being admitted for orthopaedic surgery, from a care home or those that have had a previous positive MRSA result should have a routine swab sent for MRSA on admission to hospital. In this case a swab was not collected as that was not standard at that time. Surgery would not be held up awaiting the outcome but it would have allowed earlier identification of MRSA which could impact the outcome in another case where emergency surgery is required and there is an infection post operatively. Patients admitted for elective surgery have a MRSA swab collected 12 weeks prior and receive decolonisation treatment for a positive MRSA result prior to surgery. The inquest was told this change had been rolled out in the trust and was seen as wider learning that could prevent future deaths within the NHS.
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 30th 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 Mr [redacted] son of the deceased, and Tameside General Hospital, 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** **05.10.2020**