REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS • **THIS REPORT IS BEING SENT TO: NHS England & Secretary of State of 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 1st May 2019 I commenced an investigation into the death of Maurice Leech. The investigation concluded on the 20th May 2021 and the conclusion was one of **accident.** The medical cause of death was 1a Frailty 1b Peri-prosthetic fracture of right femur 1c Fall II Chronic obstructive pulmonary disease, Type 2 diabetes, Heart Failure
4	**CIRCUMSTANCES OF THE DEATH** Maurice Leech had an accidental fall at Thorncliffe Grange Nursing Home. He was admitted to Tameside General Hospital where it was identified he could not straighten his leg. A fractured neck of femur was ruled out. A further x-ray of the femur was not carried out. He was discharged back to Thorncliffe. His leg was swollen, and he appeared to be in pain. He was reviewed by telephone by the GP but not examined due to Covid. On 13th April 2020 he returned to Tameside General Hospital where there was an x-ray which identified a fracture of the femur. It was decided he was not fit for surgery and he was discharged back to Thorncliffe on 18th April for palliative care. He deteriorated and died at Thorncliffe on 30th April 2020.
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. – 1. The inquest heard evidence that pre Covid Mr Leech would have been examined face to face by the GP rather than a telephone consultation without an examination. The evidence indicated that a physical examination would probably have resulted in Mr Leech being referred back to hospital at an earlier stage. 2. Mr Leech was very vulnerable and a poor historian. Due to Covid he was sent alone to hospital and seen alone there. The evidence before the inquest was that if support had been available a more accurate picture of his baseline and needs would have assisted staff in treating him and potentially identifying that he should not be discharged back to the care home and that a fracture would not

	have been missed. 3. The inquest heard that he was in significant pain from the fracture to the femur. Unlike the position relating to a fracture to the neck of femur there is no NICE guidance for treatment of such fractures to ensure a consistent approach to management of them in the elderly across the NHS. This included in Mr Leech's case how to effectively manage his pain and the impact of that on his overall health.
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 18th October 2021. 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] (family 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	**23rd August 2021**  **Alison Mutch** **HM Senior Coroner Greater Manchester South**