REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Tameside and Glossop Integrated Care NHS Foundation Trust and the Greater Manchester Health and Social Care Partnership
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 November 2021 I commenced an investigation into the death of James Robert Curry. The investigation concluded on the 30th June 2022 and the conclusion was one of **Narrative: Died from the recognised complications of a fractured neck of femur following a fall when the necessary operation took place outside the recommended timescale and followed a lengthy wait in the emergency department.** The medical cause of death was **1a) Bronchopneumonia 1b) Fracture Neck of Left Femur**
4	CIRCUMSTANCES OF THE DEATH James Robert Curry was active and lived independently. Around lunchtime on 13th November 2021, he had an accidental fall. He was taken to Tameside General Hospital. He was found to have a fractured neck of femur. He waited approximately 12 hours on a trolley in a draughty corridor before he was admitted to AMU. Planned surgery on 14th November did not take place due to lack of capacity in theatre and a shortage of orthopaedic beds. On 15th November, it was decided he required on echocardiogram, the reasons were unclear. That took place on 16th November. The operation did not proceed on that day due to the lack of theatre capacity. On 17th November 2021 he was operated on. He was in a weakened condition due to repeated NBM and not being able to mobilise. On 18th November he began to deteriorate rapidly and died at Tameside General Hospital on 18th November 2021 from bronchopneumonia.

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 that a lengthy wait for an elderly patient with a hip fracture on a trolley in the Emergency Department will impact their physiological reserves and add to their pain. In Mr Curry's case, the Inquest heard that the prolonged wait was due to a shortage of beds within the Trust. That situation is still the case; 2. Mr Curry needed an orthopaedic bed to enable him to have the operation. The evidence was that a shortage of beds meant that he could not be placed in one and had to go to AMU. As a consequence on admission he did not receive the orthogeriatric care envisaged by NICE in their guidance; 3. The Inquest heard that the operation should have taken place earlier than it did under the NICE guidance. The Inquest was told that the NICE guidance is based on ensuring the best outcomes for elderly patients with fracture neck of femur and reducing mortality. It did not due to a shortage of capacity in the Trust. The Inquest heard that the Trust was regularly not able to operate in timescales compliant with the NICE guidance.
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 29th September 2022. 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] on behalf of the Family, 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**  **04.08.2022**