REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health and Social Care
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 10th March 2022 I commenced an investigation into the death of Margaret Ena Warwick. The investigation concluded on the 15th July 2022 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a) Acute Myocardial Infarction; 1b) Operative repair right neck of femur fracture; II) Ischaemic heart disease, Left ventricular dysfunction**
4	CIRCUMSTANCES OF THE DEATH Margaret Ena Warwick lived independently. She had significant ischaemic heart disease and left ventricular dysfunction. She had previously had a myocardial infarction. She was not a suitable candidate for heart surgery. On 23rd February 2022 she had an accidental fall at home. She was taken to Tameside General Hospital where a fracture to the neck of femur requiring surgery was identified. A suspected pulmonary embolism was ruled out. There was an identified need for a pre-operative cardiac review, which did not take place until 28th February 2022. An MDT took place on 1st March and it was agreed a HDU bed was required. A shortage of beds meant surgery was delayed until 3rd March 2022. She initially made a good recovery post operatively but then began to deteriorate. She died at Tameside General Hospital on 7th March 2022.
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 heard that under the NICE guidance where a patient needs an operation for a hip fracture such as in Mrs Warwick's case and needs optimising, that optimisation should be dealt with expeditiously. In Mrs Warwick's case she needed cardiology assessment. That delay was due in part to a shortage of cardiologists at the trust exacerbated in particular by a lack of cover by cardiologists over weekends and OOH. The Inquest heard that there was no facility for a patient such as Mrs Warwick to be assessed by cardiology over the weekend; 2. Even after the assessment the Inquest heard evidence that there was a further delay due to a shortage of theatre capacity at the Trust. 3. The delay was further compounded by a shortage of HDU beds at the Trust. The Inquest heard that the Trust was trying to manage this but this shortage was part of a national shortage of HDU beds.
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 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**  **04.08.22**