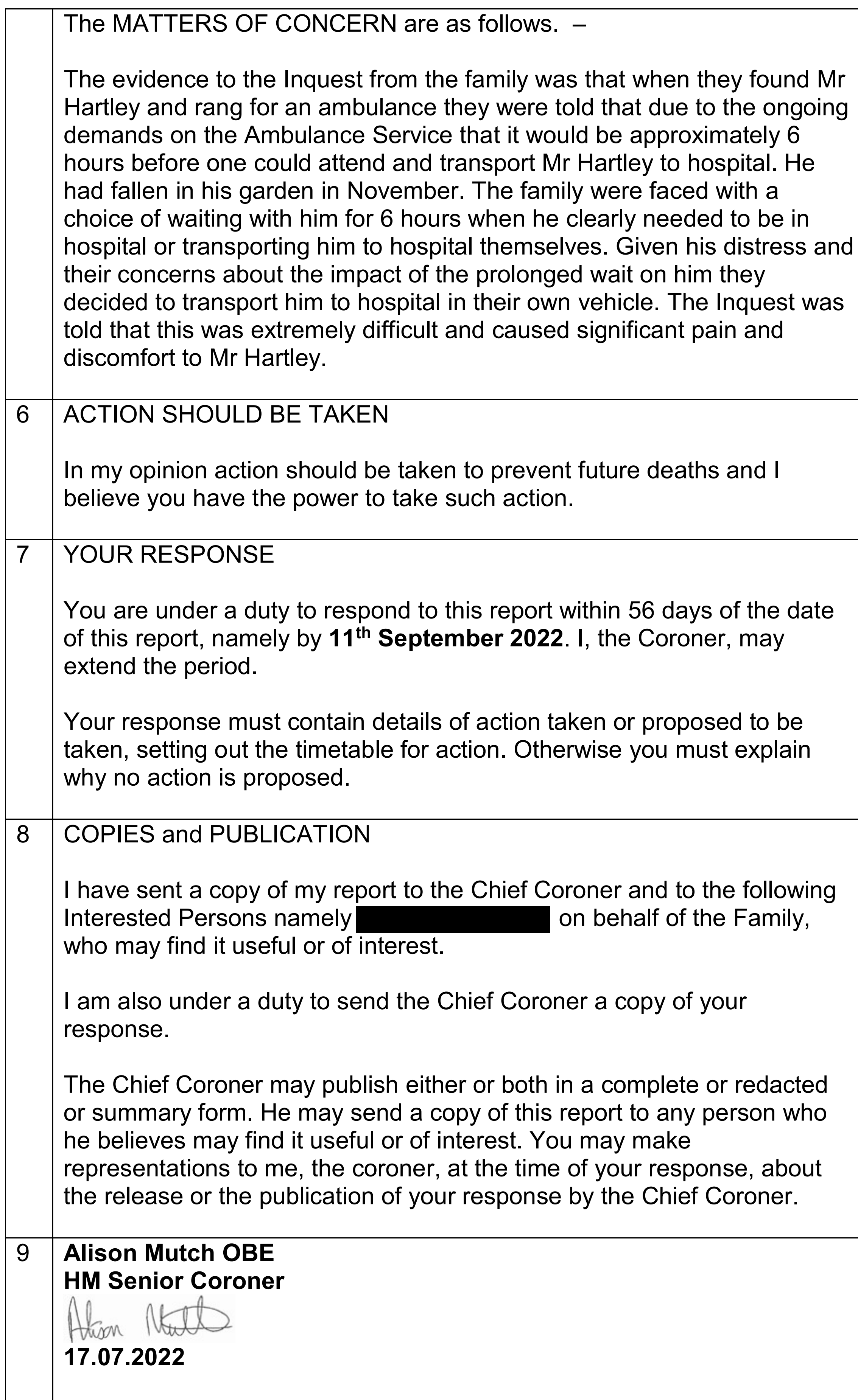
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The 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 25th November 2021 I commenced an investigation into the death of Ronald Hartley. The investigation concluded on the 13th June 2022 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a) Frailty; 1b) Fractured Neck of Femur (Operated on); 1c) Fall**
4	CIRCUMSTANCES OF THE DEATH Ronald Hartley had an accidental fall in the garden at his home address. He was taken to Stepping Hill Hospital by his son after they were told the wait for an ambulance would be about 6 hours. At Stepping Hill Hospital, he was found to have a fractured neck of femur. He was subsequently operated on. Post operatively he initially recovered well, but then deteriorated which led to him becoming increasingly frail. On 22nd November 2021, he died at Stepping Hill 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 evidence to the Inquest from the family was that when they found Mr Hartley and rang for an ambulance they were told that due to the ongoing demands on the Ambulance Service that it would be approximately 6 hours before one could attend and transport Mr Hartley to hospital. He had fallen in his garden in November. The family were faced with a choice of waiting with him for 6 hours when he clearly needed to be in hospital or transporting him to hospital themselves. Given his distress and their concerns about the impact of the prolonged wait on him they decided to transport him to hospital in their own vehicle. The Inquest was told that this was extremely difficult and caused significant pain and discomfort to Mr Hartley.
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 **11th 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 OBE** **HM Senior Coroner** [signature] **17.07.2022**