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 8th March 2022 I commenced an investigation into the death of Irene Annie Davies. The investigation concluded on the 19th August 2022 and the conclusion was one of **Narrative: Died from Natural Causes contributed to by the complications of an accidental fall and an infected nephrostomy tube**. The medical cause of death was **1a) Congestive Cardiac Failure on the background of Urinary Tract Infections; II) Bleeding from a fall, Infected Nephrostomy, Atrial Fibrillation, Extra- Articular Fracture**
4	CIRCUMSTANCES OF THE DEATH Irene Annie Davies had multiple underlying health issues including congestive cardiac failure. She had a nephrostomy as a consequence of renal stones. An operation for renal stones had been delayed due to a combination of factors including delays and backlogs in elective surgery. She had repeated urinary tract infections as a consequence of the nephrostomy. On 1st March 2022 she had an accidental fall at her home address She sustained significant lacerations and bled profusely. An ambulance was called, she was identified as requiring a category 2 response. Due to demand it was in excess of an hour before an ambulance attended at her home address. She was taken to Stepping Hill Hospital. She was found to have a fracture of the vertebrae and to have symptoms of a urinary tract infection. She was treated with antibiotics. On 2nd March 2022 at Stepping Hill Hospital she was found unresponsive.

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 Mrs Davies was identified as requiring surgery and the discomfort she was in due to the renal stones and from the nephrostomy. Pre-COVID the wait time for surgery was 18 weeks. It had risen to 2 years at the time she required the surgery due to challenges in providing elective surgery during COVID. The Inquest heard that the Trust had been working to clear the backlog and reduce the waiting time but that it still stood at 12 months; 2. The evidence given to the Inquest was that after falling Mrs Davies needed an ambulance urgently - a Category 2 response. The Inquest heard that the wait for the ambulance was very distressing and arrived outside the target times due to ambulance availability in Greater Manchester at that time. The Inquest heard evidence that there was an ongoing issue of ambulance availability.
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 9th November 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 **1)** [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**  **14.09.2022**