REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: NHS England
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 January 2022 I commenced an investigation into the death of Maureen Harrop.The investigation concluded on the 27th July 2022 and the conclusion was one of **Narrative: Died from Urosepsis contributed to by the fracture neck of femur, a complication of the fall which was operated on outside the recommended timescale.** The medical cause of death was **1a) Urosepsis; II) Fracture Neck of Femur treated surgically**
4	CIRCUMSTANCES OF THE DEATH Maureen Harrop had an accidental fall at the care home where she resided. She attended Tameside General Hospital on 20th December 2021 at about 22:47. She had a fracture to the neck of femur. She remained in the Emergency Department until being transferred to the Orthopaedic Ward on 22nd December 2021 at about 02:00. She required surgery for her neck of femur fracture. The operation did not take place until 28th December 2021 due to a shortage of theatre capacity. Post operatively, she recovered slowly and her mobility was significantly reduced. On 12th January 2022 as part of the discharge planning, the catheter previously inserted for urinary retention was removed. She subsequently had periods of incontinence. On the 21st January 2022, her NEWS 2 score increased and she became unresponsive. Tests identified she had a urinary tract infection. She was treated with antibiotics and fluids. She continued to deteriorate and died at Tameside General Hospital on 21st January 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 Mrs Harrop had a prolonged stay in the ED at the Hospital because of lack of bed capacity. The Inquest heard that given her age and the fracture the impact of the prolonged wait on her was significant particularly in light of the lack of support available to her; 2. The evidence at the Inquest was that the NICE guidance promotes surgery within 36 hours. In Mrs Harrop's case that was not achieved due to a lack of theatre capacity. The impact of the delay on her overall physiological reserves was significant
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; 2) 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 OBE** **HM Senior Coroner**  **14.09.2022**