REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive of NHS Greater Manchester Integrated Care
1	**CORONER** I am Catherine McKenna, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 23 May 2022 an investigation into the death of Violet Elizabeth Howard was commenced. The investigation concluded at the end of the inquest on 2 September 2022. I recorded a conclusion of Natural Causes. The medical cause of death was recorded as 1a) Sepsis 1b) Hepatic abscess 2) Extensive eczematised psoriasis, Psoriasis with arthropathy and Type 1 Diabetes Mellitus
4	**CIRCUMSTANCES OF DEATH** Ms Howard was admitted to Fairfield General Hospital on 13 March 2022 and diagnosed with sepsis caused by a hepatic abscess. She was transferred to the Royal Oldham Hospital (ROH) and underwent two procedures to drain the abscess. The abscess recurred and was not amenable to surgery because of its size and location. During the admission, Ms Howard developed a skin rash which required specialist dermatology input. From 22 April 2022, attempts were made by the treating team at the ROH to obtain dermatology input into Ms Howard's care. This involved enquiries with Manchester Royal Infirmary, Withington Hospital and Salford Royal Hospital (SRH). The outcome of those enquiries was that even though Ms Howard was an inpatient at the ROH, a referral to the dermatology service covering ROH had to be made through her GP. The referral from Ms Howard's GP was made and subsequently rejected on the basis that her postcode fell outside of the dermatology service's catchment area. By 27 April 2022, Ms Howard's skin condition was considered a dermatological emergency and as such she met the criteria for input from the dermatology team at SRH. I heard that the SRH dermatology clinic does not offer a service on 28 April and an appointment was made for Ms Howard to attend SRH on 29 April. Ms Howard was not able to attend this appointment as her condition deteriorated further on 28 April. A Consultant Dermatologist from SRH attended on Ms Howard at ROH on 1 May 2022 and diagnosed extensive eczematised psoriasis. This condition had impacted on Ms Howard's fluid balance, renal function and general reserves and is a contributory factor in her death. Whilst the evidence did not meet the required standard to show that earlier dermatology input would have averted Ms Howard's death, it would have mitigated the distress, discomfort and pain she experienced towards the end of her life.
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) There is a gap in the commissioning arrangements for dermatology services covering in-patients at the Royal Oldham Hospital. Those arrangements do not cover in-patients who are from outside of the Oldham area unless and until they become 'emergency dermatological cases' and meet the criteria for input from dermatology at Salford Royal Hospital.

6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **31 October 2022** I, the Area 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] • Northern Care Alliance NHS Trust 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 from. 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.
	Date: 2 September 2022 Signed: