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 18th March 2022 I commenced an investigation into the death of Ellen Lillian MacFarlane. The investigation concluded on the 7th September 2022 and the conclusion was one of **Narrative: Died from complications of a neck of femur fracture from an accidental fall where surgery took place outside the recommended timescales.** The medical cause of death was **1a) Bronchopneumonia; 1b) Neck of Femur Fracture (operated on); 1c) Fall; and 2) Dementia**
4	CIRCUMSTANCES OF THE DEATH Ellen Lillian MacFarlane had an accidental fall at her care home. She had to wait for over 5 hours for an ambulance due to demands on the ambulance service. At Tameside General Hospital, it was identified that she had a fractured neck of femur. On 3rd February 2022 she was operated on. Post-operatively she was initially stable but with significantly reduced dietary intake. On 21st February she began to deteriorate and was given antibiotics for a suspected infection. She continued to deteriorate and died at Tameside General Hospital on 12th March 2022.

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 evidence that notwithstanding her age and frailty Ellen MacFarlane had to wait over 5 hours for an ambulance. This was due to the demands on the North West Ambulance Service on the day in question. The inquest heard that such delays were not unusual and were still occurring. The reason for the delay was a shortage of ambulance crews/vehicles due to a combination of high demand, staffing shortages and delays at ED; 2. Evidence before the inquest indicated that over a weekend Ellen MacFarlane required cardiac tests that could not be provided easily in a District General Hospital setting due to availability of services/staff at DGHs out of hours. As a consequence where an operation for a fractured neck of femur has been put on hold pending further tests there is an inbuilt additional delay over a weekend before a decision can be taken as to the optimum point at which to operate. This situation at DGHs appears to create a situation which is inconsistent with the drive to operate at the earliest possible point when a patient has been optimised to secure the best outcome as set out in the NICE Guidance.
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 30th December 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 Mrs MacFarlane's Family and Polebank Hall Care Home, 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**  **04.11.2022**