REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [REDACTED], Director of Nursing and Integrated Governance, Tameside and Glossop Integrated Care NHS Foundation Trust.

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 3rd November 2022, I opened an inquest into the death of Mrs Joan Robinson, who died at Tameside General Hospital, Ashton-under-Lyne on 30 June 2022, aged 88 years. The investigation concluded at the end of the inquest which I heard on 23rd November 2022.

A post mortem examination concluded Mrs Robinson died as a consequence of:-

1a) Congestive cardiac failure;

b) Ischaemic and valvular heart disease with superimposed cervical spinal trauma following a fall.

The conclusion of the Inquest was one of Accident.

CIRCUMSTANCES OF THE DEATH

Mrs Robinson was admitted to hospital having sustained multiple cervical spinal fractures in a fall at her home. Following consultation with the regional neurosurgical centre, Mrs Robinson was treated conservatively by means of immobilisation.

Shortly after her admission, Mrs Robinson developed acute confusion, and reported pain in her throat. She was noted by nursing staff to have a poor oral intake, and eventually referred for a dietician review. Whilst in hospital, Mrs Robinson lost her ability to swallow safely, and due to her injuries and the treatment for it, difficulties were encountered in siting a nasogastric tube.

Having exhibited signs of atrial fibrillation just over a week into her admission, Mrs Robinson started showing signs of congestive cardiac failure. Her condition worsened with increasing oedema, acute kidney injury and a raised white cell count and a decision was made to institute palliative care.

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 court heard evidence that, despite training on the Malnutrition Universal Screening Tool being regarded by the Trust as 'essential', the completion rate of training within the organisation is currently just 58.74%;

2. Connected with the above, it is a matter of concern that whilst the Trust describes this training as 'essential' it is not deemed mandatory for completion by certain staff groups such as nurses and healthcare assistants;

3. It is a further matter of concern given the importance of adequate nutrition and hydration as a part of basic patient care, that the Trust's own internal investigation into the care and treatment provided to Mrs Robinson has found that the '*Nutrition and Hydration Committee* [is] *not consistently supported, held or attended'*.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 20th January 2023. 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, to [REDACTED] on behalf of Mrs Robinson's family, and to [REDACTED] of Weightmans LLP, solicitors to the Trust.

I have sent a copy of my report to the Care Quality Commission, 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.

Dated: 25th November 2022

Signature:

Chris Morris HM Area Coroner, Manchester South.