REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] Secretary of State for Health and Social Care.

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 31st March 2022, Alison Mutch OBE, Senior Coroner, opened an inquest into the death of Lynn Moss who died on 12th March 2022 at Tameside General Hospital, Ashton-under-Lyne, aged 75 years. The investigation concluded with an inquest which I heard on 28th October 2022.

The inquest determined that Mrs Moss died as a consequence of:-

1a) Sepsis;

1b) Lobar pneumonia;

II) Rhabdomyolysis due to immobility after a fall at home, chronic liver disease, hypertension.

The conclusion of the inquest was one of Accident.

CIRCUMSTANCES OF THE DEATH

Mrs Moss had been in poor health for a number of years and was effectively housebound. On 11th March 2022, her son found her on the floor at her home, having apparently fallen or collapsed. It was evident to him Mrs Moss was seriously unwell and had probably been on the floor for a considerable period of time.

An ambulance was called and Mrs Moss was taken to Tameside General Hospital where, despite treatment, she sadly died the following day.

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. –

Over the course of the inquest, the court heard evidence to the effect that:

1. Despite the seriousness of her condition, Mrs Moss waited over 5 hours from arrival at the Emergency Department until she was fully assessed by a doctor;
2. Mrs Moss waited for around 19 hours in the Emergency Department before a bed was to become available for her on the Acute Medical Unit;
3. Across both units, there were a number of missed opportunities to recognise a deterioration in Mrs Moss's condition.

The court heard as to a number of steps the Trust has taken locally to reduce risk to patients including increasing initiation of treatment prior to medical review, and making plans to expand the footprint of the Emergency Department.

Notwithstanding such measures, it is a matter of residual concern that systemic problems within the health and social care sectors including difficulty in accessing primary care and delayed discharges combine to lead to persistently high levels of demand on hospital Emergency Departments. Such sustained demand makes timely and effective monitoring of a patient's condition (and the delivery of urgent treatment where indicated) increasingly difficult, thus creating an ongoing risk of future deaths.

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 **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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, Mrs Moss' family, together with Weightmans LLP on behalf of the Mental Health Trust.

I have also sent a copy to the Care Quality Commission and Tameside Metropolitan Borough Council 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: **4th November 2022**

Signature: Chris Morris HM Area Coroner, Manchester South.