	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Barnsley District General Hospital**
1	**CORONER** I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District)
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 5 November 2021 I commenced an investigation into the death of Margaret Russell born on 26 October 1938. The investigation concluded at the end of the inquest on 27 October 2022. The conclusion of the inquest was:- Margaret Russell was admitted to hospital on 31 October 2021 following a fall at home. This resulted in a fractured hip. She required surgery for that fracture. As part of the booking in process it was apparent that Margaret may have difficulties with swallowing and eating and a speech and language therapy referral was requested. This was subsequently missed by the ward and a referral was not made; further there were no mitigating temporary measures taken to manage Margaret's diet. Margaret was provided with a meal following her surgery on 1 November 2021. She choked on that meal. Initial measures were taken to remove the blockage however CPR was not commenced due to a DNA CPR in place. The failure to provide CPR was contrary to Trust and Resuscitation Council policy. She died at Barnsley Hospital on 1 November 2021. The medical cause of death was: 1a: Respiratory Arrest 1b: Aspiration 2: Ischaemic heart disease, diabetes mellitus
4	**CIRCUMSTANCES OF THE DEATH** On 31 October 2021 Margaret Russell was admitted to Barnsley District General Hospital following a fall at home. She suffered a fractured hip as a result of the fall and required surgery for this. During her booking in process staff were made aware that Margaret may have difficulties with swallowing, and this was noted on her records. Unfortunately, this was missed by ward staff and following her procedure she was provided with a meal which she choked on. Emergency responses were instigated however the medic attending noted the DNR in place for Margaret and did not commence CPR. This was a breach of the Trust and Resuscitation Council Policy and may have led to a different outcome for Margaret.

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 could 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 decision not to commence CPR in these circumstances was not in accordance with Trust or National Policy and in some cases may make a significant difference to outcome.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 17th February 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Mrs Russell's family and Barnsley District General Hospital. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**22nd November 2022**  Abigail Combes **Assistant Coroner**