REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The 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 24th May 2022 I commenced an investigation into the death of Benjamin Paul Stanley. The investigation concluded on the 15th November 2022 and the conclusion was one of **Narrative: Died as a consequence of malnutrition caused by chronic pancreatitis contributed by liver cirrhosis and the complications of necessary antibiotic therapy**. The medical cause of death was **1a) Multi organ failure; 1b) Malnutrition; 1c) Chronic Pancreatitis; II) Clostridium Difficile Infection, Liver Cirrhosis, Sepsis**
4	CIRCUMSTANCES OF THE DEATH Benjamin Paul Stanley developed chronic pancreatitis. He became severely malnourished as a direct consequence of his chronic pancreatitis. He was admitted to Stepping Hill Hospital on 11th May 2022 and was very unwell. He had become severely malnourished. It was identified that he had liver cirrhosis in addition to the chronic pancreatitis. He was treated but continued to deteriorate. He developed sepsis and was treated further. He was found to have developed clostridium difficile probably as a consequence of antibiotic therapy. He died at Stepping Hill Hospital on 19th May 2022.
5	<u>CORONER'S CONCERNS</u> 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. – The Inquest heard evidence of significant waits in Accident and Emergency (A&E) to be seen due to the pressure on the department. The Inquest heard that the position had not improved since his death and there were regular waits in excess of 11 hours in A&E due to demand on services which impacted on patients care and treatment. The position was not unique to the particular Trust but was replicated in Trusts across Greater Manchester. The Inquest was told that prolonged waits in A&E were also due to a lack of beds with the hospital. In Mr Stanley's case direct entry to a ward would have been in his best interests. However lack of capacity meant that he had to be advised to go to A&E and wait for a bed.
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 1st April 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 namely Mr Stanley on behalf of the Family and Stockport NHS Foundation Trust via Hempsons Solicitors, 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.
	Alison Mutch OBE **HM Senior Coroner**  **04.02.2023**