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 4th July 2022 I commenced an investigation into the death of Patricia Grace Eileen Green. The investigation concluded on the 11th January 2023 and the conclusion was one of **Narrative: Died from Covid 19 pneumonia contributed to by a fall with a prolonged long lie following the fall.** The medical cause of death was **1a) COVID-19 Pneumonia on a background of a fall with a long lie; II) Chronic Obstructive Pulmonary Disease, Ischaemic Heart Disease, Frailty, Acute Renal Failure.**
4	CIRCUMSTANCES OF THE DEATH Patricia Grace Eileen Green had an accidental fall at her home address. She fell in such a way that she was left in a prone position on the floor. An ambulance was called. There was a 9 hour wait for the ambulance due to the demands on the ambulance service. She remained prone on the floor during the wait. She deteriorated particularly in relation to her breathing whilst waiting for an ambulance .She was unable to access toilet facilities whilst waiting for an ambulance On arrival at Tameside General Hospital, she was seen by a doctor after a 3 hour wait. She was found to have Covid 19 pneumonia. She continued to deteriorate and died at Tameside General Hospital on 30th June 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. – 1. Mrs Green had a long wait for an ambulance, despite her age and the recognised risks of being on the floor for a prolonged period of time, due to a shortage of ambulances. Mrs Green deteriorated whilst waiting to be taken to hospital. The Inquest heard that the shortage of ambulances was due to a number of factors including high demand and a shortage of crews due to long delays at Emergency Departments (ED) across the Greater Manchester to offload patients; 2. The evidence before the Inquest was that the delay on the day Mrs Green was waiting for an ambulance was not unusual and still remained the case on the day of the Inquest; 3. The Inquest heard that Mrs Green's wait of 3 hours in ED was not unusual and was due to the volume of patients waiting to be seen and the overall demand on ED. The consequence was that elderly frail patients were receiving treatment that was delayed and in circumstances that were challenging for frail patients.
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 Mrs Green's son on behalf of the Family and the North West Ambulance Service, 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**  **04.02.2023**