REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: NHS England
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 10th February 2023 I commenced an investigation into the death of Albert Dovey. The investigation concluded on the 30th June 2023 and the conclusion was one of **Narrative: Accidental death exacerbated by underlying heart failure.** The medical cause of death was **1a) Frailty; 1b) Rhabdomyolysis and fractured clavicle; 1c) Fall;) II Heart failure, Acute kidney injury**
4	CIRCUMSTANCES OF THE DEATH Albert Dovey had an accidental fall in his home address. He was found on the floor at his home address. He was admitted to Tameside General Hospital where he was found to have rhabdomyolysis. His oxygen requirement was significant. He had an acute kidney injury and required a blood transfusion. He had heart failure. He was treated with antibiotics. He was found to have fractured his clavicle which further reduced his mobility. He became gradually frailer as a consequence of his reduced mobility in combination with his heart failure despite treatment. On 4th February 2023 he died at Tameside General Hospital.
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 that in relation to Mr Dovey there had been

	delays in him being assessed by clinicians due to delays in the ambulance attending after he was found on the floor and due to delays for ambulances to be processed at the hospital. The ambulance Mr Dovey was in a queue behind other ambulances waiting to unload patients into A and E. The inquest heard evidence that delays in treatment of elderly frail patients following a fall gave rise to an increased risk of death. In Mr Dovey's case the delays were due to the sustained pressure on services across Greater Manchester which had been ongoing for months at the time of Mr Dovey's death. The pressure was due to demand against availability of resources.
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 15th September 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 [redacted], 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** **HM Senior Coroner**  **21.07.2023**