REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **1) Secretary of State for Health and Social Care, and; 2) Greater Manchester Integrated 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 11th January 2023 I commenced an investigation into the death of Bernhard John Marek .The investigation concluded on the 31st May 2023 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a) Hospital Associated Pneumonia; 1b) Fractured Neck of Femur (operated); II) Squamous Cell Carcinoma Lung, Acute Kidney Injury**
4	CIRCUMSTANCES OF THE DEATH Bernhard John Marek (date of birth 2nd October 1946) had an accidental fall whilst walking from his car to a coffee shop. He could not weight bear following the fall. An ambulance was called. There was a 16 hour wait for an ambulance at that point. He was outside in the street in December. He was moved with assistance from members of the public to his car and driven home where an ambulance was again called for. He remained in his car whilst waiting for an ambulance as he could not mobilise from the car. The ambulance took him to Stepping Hill Hospital. He was diagnosed with a fracture to the neck of femur and admitted after a 9 hour wait in the emergency department. He was operated on. Post operatively his kidney function deteriorated further from his baseline. He required oxygen and his early warning score fluctuated. On 6th January 2023 he deteriorated rapidly having developed pneumonia. He died in Stepping Hill Hospital on 6th January 2023.
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 was told that the wait time that was given at the time of the initial call was due to demand on the ambulance service and that such delays were not unusual throughout December due to demand and resources. As a consequence frail elderly patients such as Mr Marek with hip fractures were regularly waiting significant periods of time for the ambulance service. The resource issues faced by the ambulance service were exacerbated by long delays faced by ambulances to offload patients at Emergency Departments.
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 13th 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] on behalf of the Family, 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**  **19.07.2023**