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 19th August 2022 I commenced an investigation into the death of Evelyn Mary Dutton. The investigation concluded on the 4th May 2023 and the conclusion was one of **Narrative: Died from natural causes contributed to by complications of an accidental fall, poor nutritional status and complications of necessary medication.** The medical cause of death was **1a) Multi-organ failure; 1b) Frailty; II) Multiple Duodenal Ulcers, Fracture left hip with Hemiarthroplasty, Poor Nutritional Status, Systemic Sclerosis**
4	CIRCUMSTANCES OF THE DEATH Evelyn Mary Dutton had severe Systemic Sclerosis. She was admitted to Stepping Hill Hospital following an accidental fall at her home address. It was identified that she had fractured her neck of femur. She was operated on. Post-operatively her weight was found to be low and she was referred to the dietetics team. Her nutritional status remained compromised and an Nasojejunal (NJ) tube was sited on 21st July 2022. There was a delay in utilising the NJ Tube until 29th July. The NJ feeding was subsequently stopped due to concerns of aspiration and fluid overload. It was restarted on the night of 4th August. There was a significant electrolyte imbalance, probably due to refeeding syndrome due to the issues with nutrition. On 5th August the feeding via the NJ Tube was stopped due to episodes of vomiting of blood from her gastro intestinal issues including duodenal ulcers, identified in a series of gastroscopies, probably caused by steroid treatment. She continued to become increasingly frail. She deteriorated further and died at Stepping Hill Hospital on 13th August 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. The inquest heard evidence that after her fall, on 28th June 2022, despite her age and frailty there was a prolonged wait for an ambulance to take her to hospital. This was due to the demands on the ambulance service that day. Once they reached hospital Mrs Dutton had to remain in the ambulance until a space became available for her in the Emergency Department. This was due to the pressure on the Emergency Department and was replicated across Greater Manchester. Once in the Emergency Department she then remained there until transfer to a ward on 29th June when a bed became available; 2. The evidence was that long waits for transfer to hospital and delays in being transferred to wards presented a significant risk to the health and wellbeing of elderly frail patients with hip fractures such as Mrs Dutton. The inquest was told that these delays were not unusual in summer of 2022.
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 1) [redacted] on behalf of the Family and; 2) Stepping Hill Hospital, 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**