REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 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 30th December 2022 I commenced an investigation into the death of Thelma Mary Radmore .The investigation concluded on the 22nd May 2023 and the conclusion was one of **Narrative: Died from a combination of Influenza A and Covid Pneumonitis contracted whilst an in-patient contributed to by an unstageable sacral pressure ulcer that was exacerbated by a prolonged wait for an ambulance and a prolonged wait for treatment and a bed in the Emergency Department**. The medical cause of death was **1a) Influenza A and Covid Pneumonitis; II) Ungradable Sacral Pressure Ulcer, Type 2 Diabetes Mellitus, Hypertension, Chronic Kidney Disease**
4	CIRCUMSTANCES OF THE DEATH Thelma Mary Radmore had a complex medical history. She was taken to Stepping Hill Hospital on 11th December 2022 at 18:20 via ambulance following a prolonged delay waiting for an ambulance to become available. Due to the volume of patients at the Emergency Department Mrs Radmore waited for over an hour with the ambulance crew in a corridor on an ambulance trolley. She was then moved to a hospital trolley in a cubicle. She was in the Emergency Department for in excess 26 hours before being transferred to a ward this was due to demand for and availability of beds. On the balance of probabilities the prolonged wait for a hospital bed and delayed transfer to hospital contributed to a significant deterioration in her skin integrity. Her sacral pressure ulcer was found to be unstageable on assessment by the tissue viability nurse on 16th December 2022. On 20th December 2022 she was swabbed for Covid-19 and Influenza A. Both on balance of probabilities contracted in hospital. She was initially stable. On 22nd December 2022 she began to deteriorate rapidly with Covid Pneumonitis and Influenza A. She died at Stepping Hill Hospital on 23rd December 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 that the long wait for an ambulance and prolonged delay in the Emergency Department were due to demand on services and resources available. The inquest heard evidence that the ambulance service challenges were exacerbated by waits outside Emergency Departments for space to become available for patients; 2. The wait Mrs Radmore experienced with the ambulance crew in the corridor was due to demand for space within the Emergency Department due to patient numbers and issues with patient flow due to challenges in discharging patients from wards; 3. In Mrs Radmore's case the long delays meant that steps to reduce the risk from pressure ulcers such as a suitable mattress could not be taken at an early stage; 4. The inquest was told that the situation had been ongoing throughout the preceding days and such delays were not unusual across the North West and nationally.
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**