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; 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 1st February 2023 I commenced an investigation into the death of Thomas Barton. The investigation concluded on the 27th June 2023 and the conclusion was one of **Narrative: Died from complications of aspiration pneumonia following a prolonged hospital stay contributed to by COVID which he contracted when discharge was delayed**. The medical cause of death was **1a) Frailty; 1b) Aspiration Pneumonia on a background of Dysphagia; II) Covid, Urinary Tract Infection**
4	CIRCUMSTANCES OF THE DEATH Thomas Barton lived independently at his home address. He developed a urinary tract infection and required hospital treatment. He was admitted on 15th November 2022 to Wythenshawe hospital and then moved to Trafford General Hospital. He responded to treatment. To facilitate his discharge he needed additional support at home and remained in Trafford General Hospital whilst care arrangements were organised. Whilst waiting for the package of care to be put in place he developed COVID 19 in hospital. As a consequence he deteriorated and developed dysphagia as a consequence of his frailty which led to him developing aspiration pneumonia. Despite treatment he became increasingly frail. He was discharged on end of life care to Flixton Manor Nursing Home on 24th January 2023 and died there on 27th January 2023.

5	CORONER'S CONCERNS 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 that the delayed discharge of Mr Barton from hospital was due to the challenges of putting an appropriate social care package in place. The evidence before the inquest was that delayed discharges such as Mr Barton's put the lives of frail elderly patients at risk as it is far more likely that they will become deconditioned and develop and infection if they spend unnecessary time in hospital. The evidence was that delayed discharges such as Mr Barton's were not uncommon due to the demand on social care and the availability of suitable care. The evidence was that speedier discharges would occur if there was improved availability of social care and that this would improve outcomes for elderly patients and reduce the risk of preventable deaths occurring.
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**