



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	<p>REGULATION 28 REPORT TO PREVENT DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1 Northampton General Hospital</p>
1	<p>CORONER</p> <p>I am Hassan SHAH, Assistant Coroner for the coroner area of Northamptonshire</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 12 October 2022 I commenced an investigation into the death of Elaine Jean GRIFFITHS aged 87. The investigation concluded at the end of the inquest on 16 December 2025. The conclusion of the inquest was that:</p> <p>Mrs Elaine Jean Griffiths died on 7 October 2022 at Northampton General Hospital as a result of Covid and a deterioration in her condition triggered by a fall in the context of multiple comorbidities including heart failure which complicated the medical management.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mrs Elaine Jean Griffiths died on 7 October 2022 at Northampton General Hospital as a result of Covid and a deterioration in her condition triggered by a fall in the context of multiple comorbidities including heart failure which complicated the medical management.</p> <p>The medical cause of death was:-</p> <p>1a COVID pneumonitis 1b Congestive cardiac failure & fall resulting in fractured neck of femur</p>
5	<p>CORONER'S CONCERNS</p> <p>During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)</p> <p>Mrs G had been prescribed a high protein drink supplement (Vital 1.5 Kcal) by her GP in March 2022. She was also prescribed furosemide, a diuretic, 40mg daily to assist with fluid retention arising from congestive cardiac failure. Mrs G followed a gluten and dairy free diet. On 11 August 2022, Mrs G suffered an unwitnessed fall at home suffering a fractured neck of femur and was brought to A&E. She was frail, dehydrated, and acutely confused. On 13 August 2022, Mrs G had a MUST (malnutrition universal screening tool) score of 2 so did not meet the criteria for referral to a dietician. Four weeks later, on 14 September 2022, Mrs G's MUST score was 3 and the dietician accepted the referral, reviewed Mrs G and offered advice.</p>



	<p>Mrs G was also weighed on a regular basis. The SALT team recommended a food level of 5 (minced/moist) and later 6 (bite size). Food intake was recognised as poor. Fluid intake was a delicate balance – too much could cause pulmonary oedema; too little could cause dehydration. Given the importance of accurately monitoring both fluid and food intake in this context, I have the following concerns albeit I did not find that these matters were causative of death in the present case:-</p> <p>A) The Ward Sister said in her evidence that “on occasional days, the fluid and diet charts were only partially completed”.</p> <p>B) There was confusion about whether or not Mrs G was gluten and dairy intolerant. A Mental Health Nurse recorded on 31.08.22 “she was eating and drinking poorly as she follows a gluten and dairy free diet and reported the ward only give her lentil casseroles”. However, the Consultant/Orthogeriatric said in his evidence “..she had very poor oral intake and family were insisting she had an allergy to gluten and lactose despite Mrs Griffiths denying this”.</p> <p>C) The family say that the choice of options for those with gluten and dairy intolerance and also requiring bite sized food was very limited, which disproportionately affects the elderly.</p> <p>D) The family say that the fluid and diet charts were not accurate as the family were bringing in food and this was not being recorded. As the charts were inaccurate, this would also have made it more difficult for the dietician to offer meaningful advice.</p>
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 February 12, 2026. 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  I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	Dated: 22/12/2025  Hassan SHAH Assistant Coroner for Northamptonshire