REGULATION 28: REPORT TO PREVENT FUTURE DEATHS .

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] Managing Director, Home Care Support Ltd, Human Support Group, Craig House, 33 Ballbrook Avenue, Didsbury, Manchester, M20 3JG • [redacted] Performance Director, Home Care Support Ltd. • Trafford Metropolitan Borough Council – Social Services Department. Copied for interest to: • The Chief Coroner • The Family of the deceased • [redacted] – Home Care Support Manager
1	**CORONER** I am Nigel Sharman Meadows, H.M. Senior Coroner for the area of Manchester City.
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	**INQUEST** The inquest into the death of **Raymond David SHEPHERD** was opened on 11 February 2016 and concluded on 30 November 2016. I recorded the medical cause of death to be 1a. Hospital acquired pneumonia, II Periprosthetic left hip fracture, alcoholic liver disease, liver cirrhosis, left ventricular failure, COPD, and emphysema. I recorded an Accidental Death conclusion.
4	**CIRCUMSTANCES OF THE DEATH** 1. The deceased was born on 25 July 1953 and lived at Flat 6, 405 City Road, Old Trafford, Manchester. He suffered from chronic ill health and was only 62 years of age. He suffered from alcoholic liver disease, liver cirrhosis, left ventricular failure, COPD, and emphysema. His mobility was extremely limited. He was being prescribed medication for his various conditions but continued to drink alcohol. 2. He was initially provided with care from February 2014 and then with re-ablement support by Home Care Support after a hospital admission. He then was provided with domestic support from December 2014 and this was funded by Trafford Council. 3. This comprised domestic support which included personal care and cleaning as well as help to produce meals. He managed all of his own medication. He became well known to the Home Care Support carers and would drink alcohol every night and would on occasion refuse help. He would also cancel care visits

	and because of his poor mobility was unable to get to the toilet and would urinate in a bucket. By the time of the events in question in early January 2016 he was meant to be having two visits a day. His condition had been deteriorating generally over time. 4. His Home Care Support customer file identified a number of risks and there was a general recognition that he was at risk of falls. 5. The visiting Home Care Support carers are meant to complete a Service User Comments Book. 6. A number of issues arise from them. For example, he was meant to have two visits on 16 January 2016 but only one is recorded, similarly on 17 January 2016. On 18 January 2016 in the afternoon visit it was recorded that he had a stomach ache and didn't want anything to eat and that he reported that he'd had two falls that day and had banged his head. However, there was no call made to a GP or the ambulance service. 7. On 19 January only one visit in the morning is recorded. The following day on 20 January 2016 in the afternoon he was found lying on the floor and needed help to get on his feet. He claimed that he hadn't hurt himself but didn't want anything to eat. Again there was no call to a GP or ambulance service. It is reported that a phone call was made to the office about this and should this have happened the court was told that a record should have been kept but it is unclear whether or not any record was recorded and kept in this instance. 8. On 21 January 2016 in the afternoon it is recorded that he had had another fall overnight and that he wasn't feeling well but still no call was made to the GP or ambulance service. 9. There was a further visit on the morning of 22 January 2016 and he was noted to have a number of bruises and it is recorded that he declined to be checked over by a doctor. The entries a sequential and can be read by the staff to see the history. There was no visit recorded in the afternoon of 22 January 2016. 10. On the morning of 23 January 2016 he was admitted to Trafford Hospital having reportedly had a fall that morning having lost his balance whilst walking with a zimmer-frame. He was unable to move his left leg upwards. He was assessed and diagnosed has having suffered a fracture to his femur as well as an injury to his left shoulder. He was reviewed with a plan to take him to surgery but unfortunately his condition deteriorated and he developed a chest infection. Unfortunately, his condition did not improve despite treatment but deteriorated and he died on 30 January 2016. 11. It is not clear whether or not he had any form of mental capacity assessment undertaken but he clearly was an individual of high risk of self-neglect and suffering accidental trauma. 12. The deceased death was preventable.
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: 1. The standard and detail of the record keeping in the Home Care Support

	Service User comment book was of very poor standard. 2. The Home Care Support Customer file does not seem to have been updated and reviewed. 3. On some occasions both daily visits were not undertaken. 4. From 18 January 2016 there were at least three occasions when the deceased had either reported a fall or been found having after fallen, but no action was taken to notify the GP or ambulance service. 5. The deceased was a service user with chronic health problems which affected his mobility and was at high risk of suffering a fall as well as self-neglect. He reported not wishing to eat anything over a period of days which again should have triggered some concern. 6. Over a period of some days there seems to have been a deterioration in his condition which could have been identified and steps taken to stop it by appropriate referrals to primary health care services. In the event that led him to having a further significant fall in which he fractured a femur as well as sustaining other injuries. This in turn led to a hospital admission but he was not fit enough to undergo surgery and died. 7. There was no mental capacity assessment undertaken or a review of this arranged.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 **Friday 17 February 2017**. 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 Interested Persons. I have also sent it to organisations 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	**Friday 30 December 2016** **Mr Nigel Sharman Meadows** **HM Senior Coroner**