REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Matron / Registered Manager, The Lakes Care Centre, Lakes Road, Dukinfield, Tameside, SK16 4TX

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

Following the opening of an investigation on 31st May 2017, on 6th June 2017, Andrew Bridgeman, Assistant Coroner for Manchester South, opened an inquest into the death of Geoffrey Spencer who died on 28th May 2017 aged 90 at Tameside General Hospital, Ashton-under-Lyne. The investigation concluded at the end of the inquest which I heard on 5th October 2017.

The conclusion of the inquest was that Mr Spencer died from a respiratory arrest secondary to aspiration pneumonia. Whilst multiple serious medical problems placed Mr Spencer at risk of aspiration pneumonia, his death was contributed to by injuries sustained in an unwitnessed fall at his care home. At the end of the inquest, I recorded a narrative conclusion to this effect.

CIRCUMASTANCES OF THE DEATH

Mr Spencer first became a resident at The Lakes Care Centre in 2015 as a result of the progression of vascular dementia. Although initially Mr Spencer was relatively mobile, in November of that year he had a stroke which diminished his mobility and impaired his ability to swallow safely.

On occasion, Mr Spencer became agitated, and input was sought from the Mental Health team and the General Practitioner to try and mitigate this.

On 24th May 2017, Mr Spencer was particularly agitated, having had a restless night. At around lunchtime, he was thought to be seated in the lounge area of the Coniston Unit at

The Lakes Care Centre, which at all times was meant to be under supervision of an attendant member of staff.

At around the time some residents were being helped to the dining room for lunch, Mr Spencer was observed to be on the floor, some distance away from his chair. The evidence at inquest did not disclose how Mr Spencer had come to be on the floor, and particularly whether or not this had occurred whilst the lounge was unintended.

Later that day, Mr Spencer was noted to be in pain. An ambulance was called, and Mr Spencer was taken to Tameside General Hospital where a fractured neck of femur was diagnosed.

Although Mr Spencer was initially placed on the trauma operating list on 25th May 2017, he was not considered fit for surgery. Mr Spencer developed symptoms of respiratory problems later that day, and treatment for aspiration pneumonia was commenced on 26th May 2017. Very sadly, Mr Spencer's condition deteriorated further, and he died in hospital on 28th May 2017.

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.

Notwithstanding the serious injury sustained by Mr Spencer, and the residual possibility that this was sustained in circumstances where the lounge area was unattended by a member of staff, it is a matter of concern that no formal investigation has been undertaken in relation to this incident by The Lakes.

Whilst evidence emerged in the course of the inquest of improvements to the Care Centre's Falls Policy and more formal reporting and analysis of falls at The Lakes, it is a matter of concern that the absence of a formal investigation has reduced the potential for learning to be derived from this incident with a view to improving the safety of other residents.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st December 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

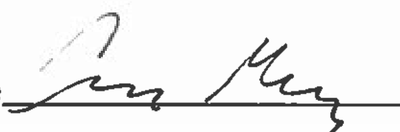
1) [redacted] (Daughter of the Deceased);
2) [redacted] (Son of the Deceased).

I have also sent it to the Care Quality Commission 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.

6th October 2017

Signature 

Chris Morris HM Area Coroner **Manchester South**