REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health
1	CORONER I am Alison Mutch ,Senior Coroner, for the coroner area of South Manchester
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 2nd October 2017, I commenced an investigation into the death of Sheila Ann Hadfield. The investigation concluded on the 17th September 2018 and the conclusion was one of Narrative: Died from the recognised complications of a natural cause exacerbated by a period of immobility following an accidental fall. The medical cause of death was 1a Sepsis; 1 b Left sided empyema and purulent pericarditis;1 c Left sided bronchopneumonia
4	Sheila Ann Hadfield had a long standing mental health disorder of paranoid schizophrenia. She resided at Chester House, a residential care home. As part of her illness she self-neglected including poor personal hygiene and refusal of food. She would regularly stay in her room for significant periods of time and refuse access to care home staff. On 17th August 2017 it was identified that a best interest meeting would be beneficial as the home was struggling to cope. There were limited opportunities for placement elsewhere.

	She went to her room on 21st September 2017. She did not come out for meals on 22nd September and refused access to her room. At about 14.00 on 22nd September 2017 she was found on the floor of her room by care staff. An ambulance was called and she was transferred to Stepping Hill Hospital. She was treated for sepsis. On 19th September 2017 she died at Stepping Hill Hospital from sepsis.
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 inquest heard that the home that Mrs Hadfield was placed in struggled to cope with her needs. However, there was a national shortage of suitable beds for individuals of a similar age to Sheila Hadfield with her complex mental health needs. The majority of available care provision was dementia beds which would have been unsuitable. The inquest was told that this meant that had Mrs Hadfield not remained where she was she would have had to go onto a mental health ward on a voluntary basis or been sectioned if she had refused.
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 22nd November 2018. 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 Mrs Evans, sister of Sheila Hadfield and

	[redacted] daughter of Shelia Hadfield , 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	Allison Mutch OBE HM Senior Coroner 27.09.29018