REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Mr Ian Trenholm, Chief Executive, Care Quality Commission, 151 Buckingham Palace Road, London SW1W 9SZ

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

On 25th October 2018, Christopher Murray, Assistant Coroner, opened an inquest into the death of Joseph Kevin Lafferty who died on 24th June 2018 at Wythenshawe Hospital, Manchester, at the age of 85 years. The investigation concluded with an inquest which I heard between 1st – 4th July 2019 and which concluded with a Narrative conclusion to the effect that Mr Lafferty died as a consequence of a fall at his care home which occurred after he left the building and gained access to an area of the grounds to which it was not intended he should have access, whilst unsupervised.

CIRCUMSTANCES OF THE DEATH

Mr Lafferty was formally diagnosed with dementia in 2014. Over subsequent years, problems with his short term memory increased and his mobility declined. In January 2018, Mr Lafferty was admitted to hospital following a fall, and treated for an infection. It was appreciated that Mr Lafferty's condition was now such that he could not safely return home.

Following assessments undertaken in hospital, it was identified Mr Lafferty required 24 hour EMI residential care. As such, on 1st May 2018, Mr Lafferty moved into The Cedars Rest Home, Bowden, Altrincham.

Whilst at The Cedars, Mr Lafferty was noted to be wandersome. At around teatime on 11th June 2018, staff at the home realised Mr Lafferty was missing. A search ensued, and he was found outside of the care home in an area it was not intended he should have access to with serious injuries. An ambulance was called at 17:41 and arrived on scene approximately two hours later.

Mr Lafferty was taken to Wythenshawe Hospital where he subsequently died. A post mortem examination concluded Mr Lafferty died as a consequence of:

1) A) Bronchopneumonia with congestive cardiac failure; due to

1) B) Thoracic trauma on the background of ischaemic heart disease and dementia.

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. –

Over the course of the inquest, evidence was heard to the effect that The Cedars Rest Home had been inspected by the Care Quality Commission in 2016 and assessed as 'Good'. Following Mr Lafferty's death, a further inspection took place and a rating of 'Requires Improvement' was arrived at.

It is a matter of concern that, according to the evidence of the Care Quality Commission Inspector who gave evidence at court, there is no requirement on inspectors to include external aspects of a registered premises in the course of a CQC inspection in every case.

Consideration should be given to such areas automatically forming part and parcel of a CQC inspection where these are routinely in use by residents in the course of the provision of regulated activities.

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 **2nd October 2019**. 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 Mr Lafferty's family, together with the legal representatives of The Cedars Rest Home and North West Ambulance Service NHS Foundation Trust.

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.

Dated: 7th August 2019.

Signature: Chris Morris HM Area Coroner, Manchester South.

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THIS REPORT IS BEING SENT TO: Professor Keith Willett CBE, National Clinical Director for Acute Care, NHS England, c/o Legal Team, 4th Floor, Quarry House, Leeds LS2 7UE.

CORONER

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The **MATTERS OF CONCERN** are as follows. –

In the course of the inquest, evidence was heard to the effect that, like other ambulance services, North West Ambulance Service NHS Foundation Trust utilisers a priority dispatch system to triage calls whereby the answers callers gave to standard questions determined the level of response provided, and the timescales within which a response can ordinarily be expected.

It is a matter of concern that the system in use at this and other ambulance Trusts does not specifically take into account the age of the patient when determining the speed and acuity of response to be provided.

ACTION SHOULD BE TAKEN

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