**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO: Chief Executive of Stockport Metropolitan Borough Council, Secretary of State for Health |
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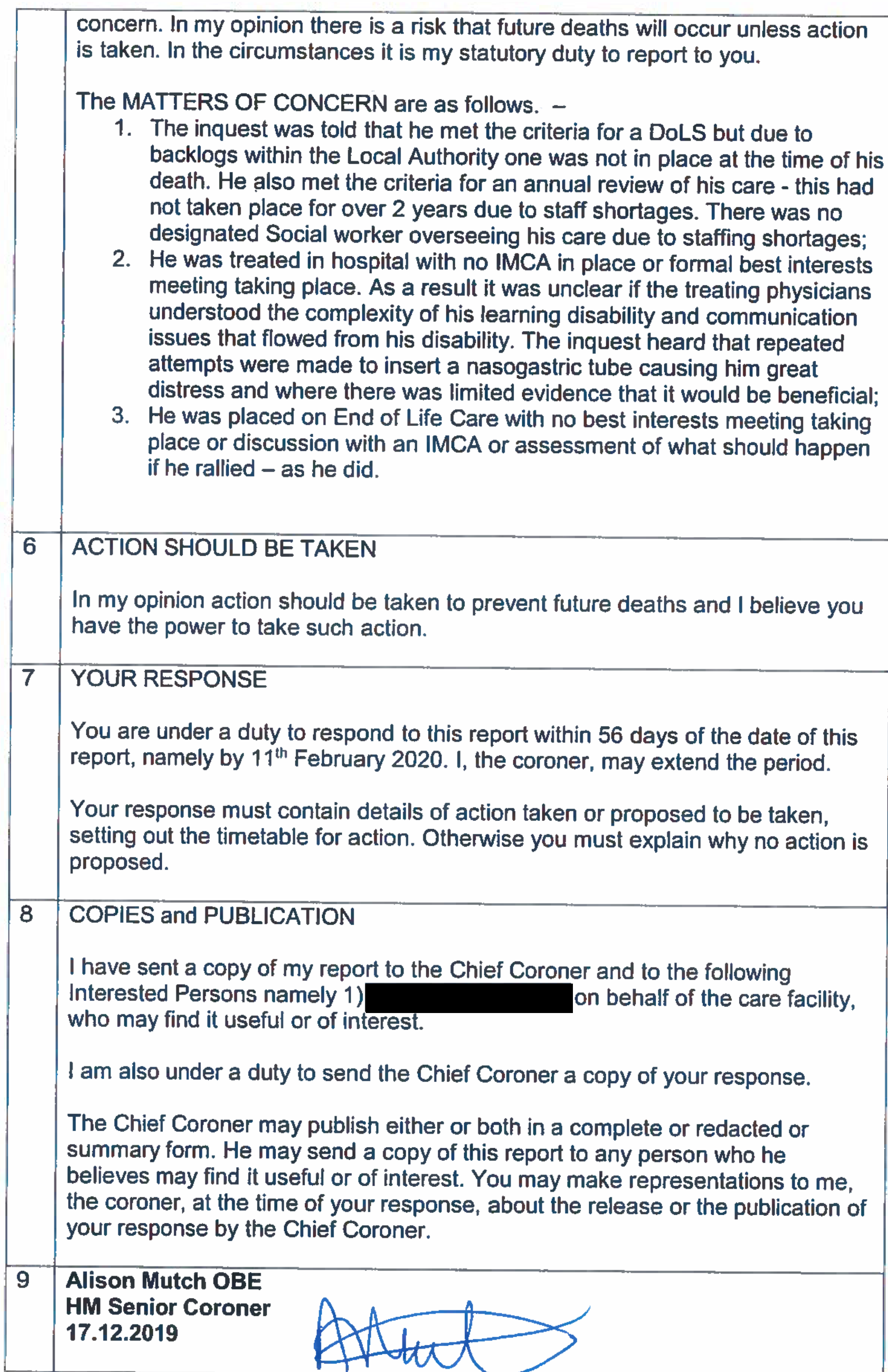
| 1 | CORONER<br><br>I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South |
| 2 | CORONER'S LEGAL POWERS<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 |
| 3 | INVESTIGATION and INQUEST<br><br>On 24th May 2019 I commenced an investigation into the death of Lewis Victor Mendelson. The investigation concluded on the 4th November 2019 and the conclusion was one of **Narrative: Died from the recognised complications of cerebral palsy (the precise cause of which could not be established).**<br><br>The medical cause of death was **1a) Aspiration pneumonia on a background of an episode of vomiting; 1b) Cerebral Palsy** |
| 4 | CIRCUMSTANCES OF THE DEATH<br><br>Lewis Victor Mendelson had profound learning disabilities and physical disabilities. He was placed by the Local Authority in a community care facility. He was not subject to a DoLS. His last statutory 12 month review took place over 2 years before his death. He had no allocated Local Authority social worker. On the night of 8th May 2019 he vomited. He was taken to hospital some hours later. Repeated attempts were made to insert a nasogastric tube causing him significant distress. He was placed on end of life care with no formal best interests meeting or Independent Mental Capacity Advocate (IMCA) in place.<br><br>He returned to his home address with end of life care. He appeared to begin to improve and antibiotics were restarted. He subsequently deteriorated again and died on 16th May 2019 at his home address, 10 Firs Grove, Gatley. |
| 5 | <u>CORONER'S CONCERNS</u><br><br>During the course of the inquest the evidence revealed matters giving rise to |



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| | 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.<br><br>The MATTERS OF CONCERN are as follows. –<br>1. The inquest was told that he met the criteria for a DoLS but due to backlogs within the Local Authority one was not in place at the time of his death. He also met the criteria for an annual review of his care - this had not taken place for over 2 years due to staff shortages. There was no designated Social worker overseeing his care due to staffing shortages;<br>2. He was treated in hospital with no IMCA in place or formal best interests meeting taking place. As a result it was unclear if the treating physicians understood the complexity of his learning disability and communication issues that flowed from his disability. The inquest heard that repeated attempts were made to insert a nasogastric tube causing him great distress and where there was limited evidence that it would be beneficial;<br>3. He was placed on End of Life Care with no best interests meeting taking place or discussion with an IMCA or assessment of what should happen if he rallied – as he did. |
| 6 | ACTION SHOULD BE TAKEN<br><br>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<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th February 2020. I, the coroner, may extend the period.<br><br>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<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely 1) on behalf of the care facility, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **Alison Mutch OBE**<br>**HM Senior Coroner**<br>**17.12.2019** |