REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: CQC, The Vicarage Residential Care Home, PH England, NHS England, Greater Manchester Health and social care partnership
1	CORONER I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater Manchester South
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 14th April 2020, I commenced an investigation into the death of Anthony Slack .The investigation concluded on the 9th October 2020 and the conclusion was one of Narrative: Died from recognised complications of Covid 19 exacerbated by an industrial disease . The medical cause of death was 1a) Community Acquired Pneumonia 1b) COVID-19 II) Dementia, Chronic Obstructive Pulmonary Disease, Asbestos Related Pulmonary Fibrosis, Pleural Plaques, Type 2 Diabetes
4	CIRCUMSTANCES OF THE DEATH Anthony Slack had underlying health issues, including asbestos related pulmonary fibrosis. He had an unwitnessed fall at the care home. The precise circumstances were unclear and not documented. He lay on the floor pending an ambulance attending. An ambulance attended after over 4 hours - as a category 3 call the target time is 2 hours. He flagged as sepsis. The view was he was likely to have Covid 19, as there were other cases in the home and his symptoms were consistent with that as well. He remained at the home where he appeared to improve until 11th April 2020. On 11th April 2020, he became unresponsive and deteriorated rapidly and was transferred to Tameside General Hospital and was placed in the Stamford Unit. He was very unwell and was moved to a palliative care pathway. He died at the Stamford Unit on 13th April 2020.
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 documentation available at the inquest from the home was limited in detail. As a result, it was difficult to understand what observations had been undertaken by care home staff who were monitoring him. 2. The evidence given at the inquest was that the observations were of limited quality notwithstanding the diagnosis of Covid 19 and his vulnerability. 3. The inquest heard that after the home went into lockdown Covid 19 was found in residents within the home. At the inquest the home were unclear if staff had brought it into the home or if the admission of residents from the community who were not tested for Covid 19 before admission were the cause of it entering the home. There was no risk assessment in place relating to admission of new residents. 4. Staff were unclear as to the PPE requirements as a result of changes to the guidance that were occurring on a regular basis and it was unclear how changes were being shared with staff and implemented. 5. The inquest heard that the ambulance was delayed due to shortages of available ambulances. The inquest was told this was driven by a number of factors. This included staff absences due to the need to self-isolate awaiting testing and the increased cleaning needs in relation to ambulances required by Covid 19. The inquest was told that at some points in the day and in some acute trusts, ambulance crews were being supported by on-site cleaning crews. This meant quicker turnaround times and increased capacity. This was not consistent and not on a 24/7 basis. As a result, ambulances were struggling to reach vulnerable and unwell members of the public and transport them to an acute setting.
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 26th January 2021. 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, 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	 **Alison Mutch** **HM Senior Coroner for the Coroner Area of Greater Manchester South** **01/12/2020**