REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Officer, Able Care & Support Services Ltd, Tameside Business Centre Enterprise Centre, Corporation Street, Hyde SK14 1AB.
1	**CORONER** I am Andrew Bridgman, Assistant 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 17.04.20 an investigation commenced into the death of Marion Glover who died on 15.04.20. The investigation concluded on the 29.10.20 and the conclusion was one of Accident. The medical cause of death was 1a Bronchopneumonia 1b Urinary tract infection 1c 2 Alzheimer's disease/dementia, Parkinson's disease, Congestive Cardiac Failure, Facial & rib injuries
4	**CIRCUMSTANCES OF THE DEATH** On the afternoon of 24.02.20 Mrs Glover suffered an unwitnessed fall in the entrance/foyer of Melbourne Court, where she had resided since May 2018. That afternoon she had been in the communal lounge area socialising following the 'luncheon club'. Although Mrs Glover was able to mobilise independently and did not need support per se, she was to be escorted back to her flat. When a care worker arrived to take Mrs Glover back to her flat she was no longer in the lounge area. Where Mrs Glover fell was not on any route back to her flat from the communal lounge. In the fall Mrs Glover sustained facial and rib fractures and was admitted to Tameside General Hospital, where it was determined that her injuries would be managed conservatively. Mrs Glover was discharged from Tameside GH to the Stamford (Rehabilitation) Unit on 06.03.20. On 15.04.20 Mrs Glover suffered a deterioration in her health and was admitted to Tameside General Hospital at around 21.00hrs, where she died later that same day.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. Residents at Melbourne Court lived independently within their own flats and that they are free to come and go as they wished, from their flats and from the building. That included those residents who were suffering from cognitive illnesses such as Alzheimer's or dementia, of which Mrs Glover was one. The entrance/exit door was not locked, other than overnight. During the course of her evidence Mrs Glover's daughter told me that on a number of occasions when she called to visit her mother she had come across other residents wandering in the corridors in a state of confusion, and who required assistance getting

	them back to the flats. Such scenarios as described were confirmed by the Senior Manager of Melbourne Court at the time of Mrs Glover's death, during the course of her evidence. As stated above Mrs Glover fell in the foyer area. This was not on route to her flat. The evidence suggested that Mrs Glover was starting to lose cognitive function and beginning to suffer confusion. We will never know but might she have been intending to go out. Had she done her absence would likely have gone unnoticed for some time. The **MATTERS OF CONCERN** are as follows. – On exploration of this issue, it became apparent that in the absence of any restriction on residents leaving the building or observation of the foyer area there is a serious risk that such residents suffering cognitive illnesses/confusion can unknowingly leave the building. In the circumstances Melbourne Court does not appear to be suitable accommodation for residents who are suffering cognitive illnesses and confusion. 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.
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 4th Feb 2020. 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, [redacted] Mrs Glover's daughter and to [redacted] Legal Services, Tameside MBC, 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	 Andrew Bridgman, Assistant Coroner 10/12/2020