REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The CQC, The Department of Health and Stockport CCG
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 10th January 2020 I commenced an investigation into the death of Philip Taylor. The investigation concluded on the 25th November 2020, and the conclusion was one of Narrative: Died from an acute kidney injury caused by significant severe dehydration. The medical cause of death was 1a) Acute Kidney Injury 1b) Dehydration II) Dementia - Lewy Body, Pneumonia
4	CIRCUMSTANCES OF THE DEATH Philip Taylor had Lewy Body Dementia. He resided in a residential care home. He became unwell with a chest infection. His fluid consumption dropped significantly. His level of dehydration was not recognised by the GP or the home. On 3rd January he deteriorated further and NWAS attended. He was severely dehydrated. He was transferred to Stepping Hill Hospital and arrived at 16:32 on 3rd January. At 16:44 he was triaged and scored 3 on NEWS 2. He was assessed to be seen within 1 hour. He waited in the corridor due to capacity issues and was not seen until 19:17. His family had repeatedly asked for him to be reviewed. Intravenous fluids were commenced. Blood test results showed a severe acute kidney injury due to dehydration. He remained in the Emergency Department until about 21:30 on 4th January as a result of bed shortages. His NEWS 2 scores showed a deteriorating picture. The observations were not repeated with the regularity set out in NICE guidance. He developed pressure sores as a result of a prolonged period of time on a trolley in the hospital. Following transfer to the Acute Medical

	unit he continued to deteriorate, despite intravenous fluids. On 6th January 2020 he died at Stepping Hill hospital.
5	<u>CORONER'S CONCERNS</u> 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. – FOR CCG 1. Mr Taylor was seen by a GP the day before he died. His risk of dehydration was not recognised. The precise observations of the GP were difficult to ascertain at the inquest for a number of reasons. • The inquest was told that the GP had been called as the care home had concerns about Mr Taylor. However, the GP did not ascertain his temperature because the inquest was told that he did not routinely carry or use a thermometer when he saw patients in a care home. The explanation provided to the inquest was that as a GP he did was not equipped with medical gadgets in the way for example NWAS staff were. • The notes relating to the visit had not been written up until the next day and the GP could not recall all of the observations. It was unclear why that had occurred. FOR DEPARTMENT OF HEALTH AND SOCIAL CARE 2. The paramedic attending was a newly qualified paramedic and as a result was using the national pathfinder tool. Mr Taylor was scoring for sepsis on the NWAS observations. However, the crew took well over an hour to leave the care home. The inquest heard that newly qualified paramedics relied on the national pathfinder tool which did not make it clear the need for an immediate expedited transfer to hospital in such circumstances. More experienced paramedics used the Manchester triage tool which was far more explicit. The inquest was told that NWAS had recognised the issue with the national tool and were adjusting their practices to avoid the risk. However, it was not clear if other Ambulance Trusts had made similar adjustments for newly qualified paramedics. FOR DEPARTMENT OF HEALTH AND SOCIAL CARE AND CQC 3. The staff in the care home were not medically qualified. The inquest heard that their ability to recognise and respond to an escalating risk of dehydration was limited. There was no national

	guidance to assist care home staff in understanding how to recognise; respond and escalate the risk of dehydration.
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 Thursday 11th February 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 and to the following Interested Persons namely [redacted], the son of Mr. Phillip Taylor, 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, Senior Coroner, for the Coroner Area of Greater Manchester South**  **17/12/2020**