REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Secretary of State for Health and Social Care, Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU, in respect of Item One of the Matters of Concern. 2. The CEO, NHS Stockport Clinical Commissioning Group, 4th Floor, Stopford House, Stockport SK1 3XE, in respect of Items One & Two of the Matters of Concern.
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 01.03.19 an investigation commenced into the death of Cyril Cheetham who died on 25.02.19. The death was reported to the Coroner by the Registrar as the original MCCD listed Streptococcal septicaemia at 1a. The investigation concluded on 22.12.20. The conclusion was one of **Natural Causes** The medical cause of death was **1a) Multiple organ failure** **1b) Streptococcal septicaemia** **1c) Bronchopneumonia** **2) Acute kidney injury**

4	**CIRCUMSTANCES OF THE DEATH** At the time of his death Cyril Cheetham was 91 years of age. He suffered with dementia and was resident at a care home where had lived for some 4 years. Following a fractured hip in 2018 Mr Cheetham could not walk, he required assistance getting in and out of bed, and assistance with personal chores. Once in his wheelchair he was able to mobilise himself around. In the early hours of 20.02.19 Mr Cheetham was noted to have become unwell. An OOH service was called (Mastercall) who advised analgesia and to contact own GP in the morning. The home contacted own GP practice at about 09.00hrs and were told to call Mastercall. This they did and were advised a GP from Mastercall would call that day. This arrangement was changed following a telephone call between Mastercall and own GP. The outcome of that conversation was that the own GP would attend the next day. That information was not relayed to the care home, who for the remainder of the day anticipated the attendance of a (Mastercall) GP to assess Mr Cheetham. Cyril Cheetham suffered a deterioration in the early evening of 20.02.20. Mastercall were called and the GP who attended arranged for Mr Cheetham to be admitted to hospital, arriving at about 23.30hrs on 20.02.19. The following morning Mr Cheetham

	was placed on an end of life pathway. He died on 25.02.19. The inquest identified a number of omissions in the care of Cyril Cheetham over the course of 20.02.19 by those caring for him. The most significant issue being the nonattendance of a GP that day following the discussion between Mastercall and the own GP, and that the home was not made aware of the change in the plan. A GP should have attended that day or obtained further information as to Mr Cheetham's condition prior to making the decision that the matter could wait until the following day. Evidence was taken from the receiving hospital as to the likely outcome with an earlier admission. The opinion of the consultant was that given Mr Cheetham's age and other conditions his risk of mortality was very high from the outset out of infection and that it was only possible that an earlier admission may have given him a better chance.

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. – The central issue in this investigation was the telephone discussion (transcribed) between Mastercall and own GP as to who would attend that day. Mastercall had already accepted that one of its GPs would attend that day, following clinical triage at about 09.00hrs and advised the care home. However, later that morning Mastercall determined to change that decision because Mr Cheetham's presentation did not fit the criteria for the 'Alternative to Transfer' (ATT) service provided by Mastercall. Primarily that he was not at risk of admission. In the opinion of the Mastercall clinician it was the own GPs responsibility to attend. That was accepted, eventually, by the own GP who determined that a same day visit was not necessary and stated he would attend the following day. The matter of concern arises from the ATT service provided by Mastercall. The evidence was that this service was developed by Mastercall, in the Northwest circa 2013, and has since been adopted nationally. In exploring the development and use of ATT with the Medical Director of Mastercall a number of issues arose. Issue One It is clear that the service was developed to reduce demand on the ambulance service, to provide an additional layer of access to medical advice for care homes where it is felt on telephone triage that there is a risk of admission. Where a risk of admission exists a Mastercall GP will attend, seemingly on the basis that the patient would likely be seen sooner. If admission is required, then that would be arranged by the attending Mastercalll GP. The aim of ATT is to reduce the number of unnecessary calls to the ambulance services from care homes. The Medical Director of Mastercall advised that the service had been a success with a 67% diversion rate of ambulances. His evidence was that there was a significant net benefit from the ATT service. He was unable to say what downsides there were or what was the measurement for negative costs. He said he was not aware of any significant adverse outcomes. The ATT services introduces an additional layer of triage based on a telephone

	conversation between a clinician at Mastercall and someone at the care home, who may be a carer or a nurse, and may be experienced or inexperienced, rather than that person calling 999. It is of concern to me that this additional layer may result in a delay in admission, which for an elderly patient with likely co-morbidities, will affect their prospects. It was accepted that there was no audit or research carried out in respect of any deaths arising from delay in admission where the ATT service was used. The net benefit seems to have been calculated by reference to resource savings alone. I am concerned that the ATT service is being resourced and provided (nationally) without any adequate or true audit of its perceived net benefit, and that its use may be costing lives, either at all or at an unacceptable level. <u>Issue Two</u> The inquest highlighted a lack of clarity as to the criteria for the ATT service. The conversation between Mastercall and the own GP highlighted the 'grey area' that exists between a routine (no risk of admission) attendance and a 'risk of admission' attendance. It is clear from the events that unfolded that Mr Cheetham clearly was at risk of admission. In my view the lack of clarity resulted in Mr Cheetham not being seen by a GP that afternoon while there was likely no difference in outcome in his case, it is clear that this existence of a 'grey area' of responsibility might result in future deaths.
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 (30th March 2021). 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], Mr Cyril Cheetham's Son, 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	**Dated this 2nd day of February 2021**  **Andrew Bridgman** **HM Assistant Coroner**