REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State of Health and Social Care, Greater Manchester Health & Social Care Partnership and Care Quality Commission.
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 24th October 2019, I commenced an investigation into the death of Alan Massam. The investigation concluded on the 15th March 2021 and the conclusion was one of accident. The medical cause of death was 1a Lower respiratory tract infection; 1b Multiple rib fractures; 1c Falls; II Acute on sub-acute subdural haematoma, advance dementia, frailty.
4	CIRCUMSTANCES OF THE DEATH Alan Massam was a resident at Reinbeck Residential Home. As his dementia progressed, his behaviour changed significantly and his family were served with a notice that they needed to make alternative arrangements. He moved to Lisburne Court, a dementia residential home. The preadmission process was not followed fully. Medication had not had any significant impact on his behaviour. Mental health services were involved in supporting the care home. He had a series of falls and was taken to Stepping Hill Hospital on 13th October 2019, 10 days after arriving at Lisburne Court. A small bleed was identified. He was discharged back to the Care Home without contact being made with the home. The home had not answered the telephone when calls were made. No observations were taken prior to discharge. No discharge notice was sent with him. On 14th October, the GP prescribed antibiotics for a suspected chest

	infection. He refused to take them and refused fluids. His family were not communicated with effectively. He had a series of falls on 15th October. On 16th October be was taken back to Stepping Hill Hospital. A further traumatic bleed to the brain was identified and also a number of recent rib fractures. He was treated with antibiotics and fluids but deteriorated rapidly and was placed on end of life care and died at Stepping Hill Hospital on 24th October 2019.
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. – 1. The inquest heard that the care of Mr Massam was complex due to his needs but there was no clear agreement or arrangement between agencies as to how to effectively share information in complex cases.in his case mental health services were involved as was the acute trust, GP and the care home but there was limited evidence of a joint approach to ensure his care was optimised. This included a limited understanding by those involved of when and how to use of s.9 assessments to reduce the risk to a vulnerable adult such as Mr Massam. 2. Mr Massam was discharged back to the care home by the acute trust. The inquest heard that the home would not have accepted him back if they had been spoken to as they did not feel they could meet his needs. The inquest heard that there is no national guidance/protocol about what an acute trust should do if attempts to contact a home are unsuccessful or about the obligation to ensure the home can accept him back in such circumstances as these. 3. The staff at the home were aware of the prescribing of medication including antibiotics. However when he refused them and fluids there was no defined escalation process which would ensure that the risk this presented was recognised and acted on. 4. Once the initial home could not manage Mr Massam and served a notice on the family there was a significant pressure to find another home that would accept him. Whilst the search was undertaken he remained in a home where staff felt they could no longer safely meet his care needs. The inquest heard that this search was exacerbated by a national shortage of suitable beds within the adult care sector for complex cases such as Mr Massam.
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 14th June 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] (family of the deceased), [redacted] who represented Stockport Metropolitan Borough Council, [redacted] from Pennine Care Legal Department, Stepping Hill Hospital Legal Department and [redacted] from Borough Care, 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: 26th April 2021 Signature: Alison Mutch HM Senior Coroner, Manchester South