REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive Tameside and Glossop Integrated Care NHS Foundation Trust
1	CORONER I am Anna Morris, assistant coroner, for the coronial area of 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 11th September 2019 an investigation into the death of Irene Ann Esaw, aged 73 years. The investigation concluded at the end of the inquest on 6th September 2021. The conclusion of the inquest was a narrative conclusion.
4	CIRCUMSTANCES OF THE DEATH The deceased lived at home with her 24-year-old grandson, who was her sole carer. The deceased suffered from dementia which was diagnosed in 2015. From October 2017, there was no formal support in place from external agencies. From that point, the deceased's grandson was responsible for attending to all the deceased's nutritional, mobility, hygiene and personal care needs. This was an unmanageable care burden for her grandson. On the 12th September 2018, the deceased was admitted to hospital in extremis. She was malnourished, dehydrated, and confused. A safeguarding concern was raised by Northwest Ambulance Service (NWAS) who were concerned about her physical presentation, her social circumstances and the care being provided to her by her grandson. Her presentation was such that it was known or ought to have been known to those treating her that she was a vulnerable adult. The deceased was admitted to Tameside General Hospital and treated for sepsis and her other acute medical conditions. The NWAS safeguarding concern was referred to the IUCT Social Workers at the hospital provided by the Tameside Metropolitan Borough Council based at the hospital. There was an assessment on the 26th September by a social worker of the deceased's care needs. This assessment failed to properly assess the deceased's capacity to make decisions about her own care needs or where and by whom they should be met. It was assessed that there were no needs identified and no support was put in place for either the deceased or her grandson. The deceased was discharged from hospital on the 28th September 2018 without any package of care in place from the Local Authority or any referrals in place from the Hospital to community-based services. At the time the deceased was discharged, a Grade 1 pressure sore to her sacrum had been identified, as well as other areas of reddening of the skin on her lower limbs. The identification of a Grade 1 pressure sore by the hospital, considering her nutritional needs and her difficulties with maintaining her own nutrition, hydration and mobility made her extremely high risk of not being able to maintain her own tissue viability. Without appropriate support I find that it was

	inevitable that the deceased would develop sores not just on her sacrum but in other areas and that she would have been too weak to mobilise herself and with her level of cognition she would not have been able to recognise her need to move herself. This should have been identified by the hospital and the deceased should have been provided with adequate support post discharge. In hospital, the deceased had benefitted from high grade medical care with nursing support and that this level of care would have been appropriate to deal with her ongoing pressure, nutritional and cognitive needs. As a consequence, I find that the Trust failed to meet the deceased's basic medical needs following discharge from hospital. As that support was not put in place, the deceased's grandson was not able to meet her complex care needs in the community. Her grandson also likely suffered from poor mental health because of his care burden. His needs as a carer were not adequately assessed or addressed at any stage during 2017-2018. As a consequence, I find on the balance of probabilities that her grandson did not meet the deceased's basic nutritional and personal care needs from the point of her discharge from hospital on the 28th September 2018 to the time of her death. As a direct result of the failure of the deceased's basic needs being met, her Grade 1 sacral pressure sore developed to a deep and infected ulceration that subsequently caused the bone to be exposed and infected. She also developed another significant ulcer that connected to her sacral ulcer and other areas of tissue damage. As a result of those untreated pressure sores, the deceased developed widespread sepsis. On the 11th November 2018, her grandson called for an ambulance. When paramedics attended at her home address, they found Mrs. Esaw in bed, propped upright and clearly deceased. The state of her clothing and the bedding was soiled with both faeces and urine and the deceased was found in an emaciated state due to malnutrition.

5	CORONER'S CONCERNS The MATTERS OF CONCERN are as follows. – 1. **Identifying and Assessing Mental Capacity** – My findings in relation to Mrs. Esaw's death were that there was a fundamental failure by the clinical and nursing staff to adequately consider and assess Mrs. Esaw's capacity to make decisions about her own care needs whilst she was a patient at Tameside General Hospital between 12th and 28th September 2018. This failure in my view, undermined her discharge planning and was one of the key reasons why the discharge was unsafe. I understand that work is ongoing in this area, but I am concerned having heard the evidence of [redacted], the Deputy Director of Nursing and Professional Standards that it is still a "work in progress" identified by this and other incidents reported to the Trust. I am concerned that there are still issues that the Trust still aren't completely compliant with and that this needs to be addressed. 2. **Recognising the Clinical Signs of Neglect** – My findings indicate that in 2018 there was no adequate consideration by the clinical or nursing staff that Mrs. Esaw's clinical presentation in of itself indicated neglect and therefore a safeguarding concern. The Trust's Safeguarding Lead [redacted] told me that following on from the Domestic Homicide Review, the Trust recognises that more work needs to be done around the recognition of what is neglect and those medical indicators of neglect. She recognised that there needs to be a strengthening of recognition in staff of safety concerns. I understand that this is part of the Safeguarding Lead's portfolio, but I am concerned that this still needs to be addressed. 3. **Multi-agency Working** – My findings reveal that in the treatment of Mrs. Esaw, there were assumptions made by the clinical team and the IUCT that the other agency was responsible for capacity and needs assessments. The effect of this was that there was never an adequate assessment of her needs completed. [redacted], the Principal Social Worker for Adult Social Care told me in her evidence that even though IUCT are on the wards at Tameside, there is still further work to be done to understand the roles that the IUCT and the clinical team are undertaking. I am concerned that this continues to need to be addressed.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of this report, namely by 11th November 2021. I, the coroner, may extend this 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: [redacted] Chief Executive Tameside Metropolitan Borough Council. NHS England I am also under a duty to send a copy of your response to the Chief Coroner

	and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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
9	**16th September 2021** Anna Morris – Assistant Coroner Signed: 

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	nutrition, hydration and mobility made her extremely high risk of not being able to maintain her own tissue viability. Without appropriate support I find that it was inevitable that the deceased would develop sores not just on her sacrum but in other areas and that she would have been too weak to mobilise herself and with her level of cognition she would not have been able to recognise her need to move herself. This should have been identified by the hospital and the deceased should have been provided with adequate support post discharge. In hospital, the deceased had benefitted from high grade medical care with nursing support and that this level of care would have been appropriate to deal with her ongoing pressure, nutritional and cognitive needs. As a consequence, I find that the Trust failed to meet the deceased's basic medical needs following discharge from hospital. As that support was not put in place, the deceased's grandson was not able to meet her complex care needs in the community. Her grandson also likely suffered from poor mental health because of his care burden. His needs as a carer were not adequately assessed or addressed at any stage during 2017-2018. As a consequence, I find on the balance of probabilities that her grandson did not meet the deceased's basic nutritional and personal care needs from the point of her discharge from hospital on the 28th September 2018 to the time of her death. As a direct result of the failure of the deceased's basic needs being met, her Grade 1 sacral pressure sore developed to a deep and infected ulceration that subsequently caused the bone to be exposed and infected. She also developed another significant ulcer that connected to her sacral ulcer and other areas of tissue damage. As a result of those untreated pressure sores, the deceased developed widespread sepsis. On the 11th November 2018, her grandson called for an ambulance. When paramedics attended at her home address, they found Mrs. Esaw in bed, propped upright and clearly deceased. The state of her clothing and the bedding was soiled with both faeces and urine and the deceased was found in an emaciated state due to malnutrition.

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