REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Health and Social Care Partnership
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 19th August 2021 I commenced an investigation into the death of Alphonso Alexander SHEARER. The investigation concluded on the 28th March 2022 and the conclusion was one of Narrative: Died from the complications of catheterisation not diagnosed until shortly before his death. The medical cause of death was 1a Urosepsis on a background of catheterisation; 1b Chronic kidney disease; II Oesophageal carcinoma, Hypertension
4	CIRCUMSTANCES OF THE DEATH Alphonso Alexander Shearer had oesophageal cancer and lost a significant amount of weight due to poor swallow. He was admitted to Manchester Royal Infirmary with acute urinary retention. He was catheterised to treat the urinary retention. He was discharged home with a catheter in place. Over the weekend of 14th and 15th August he had symptoms consistent with a urinary tract infection, a recognised complication of catheterisation. He was not seen by a GP. A urine sample was requested. On 17th August antibiotics he could not swallow were prescribed. He was not seen by a GP. At about 12:45pm a paramedic employed by the GP practice saw him and diagnosed suspected sepsis and called an ambulance. Whilst he was being transferred to the ambulance at his home address [redacted], he collapsed and died. Post-mortem examination confirmed he had died from urosepsis.

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 Mr Shearer was frail and vulnerable with very poor swallow. When prescribing the clinicians did not recognise or have a system to flag up the need for liquid antibiotics rather than tablet antibiotics. This led to him not being able to commence antibiotics on the day he was identified as needing them. The inquest heard that it is important that in the community particularly for the vulnerable there is a system for recognising what form of antibiotics are most appropriate to prescribe to avoid delay. 2. The inquest heard that the ASK MY GP system had been challenging for those involved with Mr Shearer and had made communication harder. The evidence identified that this was a particular issue for more vulnerable patients and their families. 3. The inquest heard that he had not been seen face to face by a GP and that meant that the full extent of his deterioration was not recognised until he was seen by a paramedic from the practice who called an ambulance.
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 23/06/2022. 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] (NOK), Manchester University Foundation Trust and North Trafford Group Practice, 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 HM Senior Coroner HM Corner's Court Manchester South

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