REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health and Social Care
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 April 2020 I commenced an investigation into the death of Joseph Hargreaves. The investigation concluded on the 2nd November 2020 and the conclusion was one of **Narrative: Died as a consequence of the complications of underlying swallowing difficulties.** The medical cause of death was **1a) Sepsis; 1b) Aspiration Pneumonia on a background of chronic swallowing difficulties; II) Congestive Cardiac Failure, Ischaemic Heart Disease, Hypertension**
4	CIRCUMSTANCES OF THE DEATH On 17th April 2020, Joseph Hargreaves had an unwitnessed fall at his care home. The precise circumstances are unclear. He was admitted to Stepping Hill Hospital where he was treated for sepsis due to aspiration pneumonia, caused by poor swallowing. He appeared to improve initially but deteriorated rapidly when transferred. He died at Stepping Hill Hospital on 17th April 2020.
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 inquest heard that Mr Hargreaves was a long-term resident of the care home with significant swallowing issues and poor mobility. Following lockdown his family, who had been visiting most days, could no longer visit him. On his admission to hospital his family could not attend the

	hospital and they were unclear about the events in the home leading up to his admission. The provision of information, about the events leading up to his admission; his baseline and underlying health issues, to treating clinicians was reduced. In his case it did not impact the outcome however it was clear from the evidence that it could in other circumstances cause significant challenges in delivering effective treatment quickly to vulnerable patients.
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 4th January 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] daughter of the deceased, and the management of Bankfield House Care Home, 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** **09.11.2020**