REGULATION 28: REPORT TO PREVENT FUTURE DEATHS .

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted], Medical Director, Manchester Mental Health and Social Care Trust • [redacted] Medical Director, Central Manchester University Hospitals NHS Foundation Trust • Ms S Foxall-Smith, Chief Executive, Regard Care Copied for interest to: • Chief Executive of NHS Clinical Commissioning Groups, Manchester • Care Quality Commission • Creative Support
1	**CORONER** I am Nigel Meadows, H.M. Senior Coroner for the area of Manchester City.
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	**INQUEST** On 8 January 2015 I commenced an investigation into the death of Leslie John Morrison, aged 82. The investigation concluded at the end of the inquest on 26 July 2016. The cause of death was found to be: 1a Respiratory and cardiac arrest 1b Acute aspiration of food II Ischaemic heart disease and cerebrovascular disease The conclusion of the inquest was Accident.

4	**CIRCUMSTANCES OF THE DEATH** The deceased was 82 years of age and had been born on 21 January 1932. He suffered a chronic enduring mental health condition, namely bipolar disorder. He had been treated for many years with medication to control the condition and had previous informal admissions to psychiatric units. He also suffered from a number of other physical conditions, including atrial fibrillation, bundle branch block, postural hypotension, an abdominal aortic aneurysm, overactive bladder syndrome and osteoarthritis. He had a supportive and caring family, together with the assistance of a Registered Mental Nurse who acted as his care co-ordinator. In about 2010 he moved to 299 Great Western Street, Rusholme, Manchester, which is supported care accommodation provided by Regard Care. He required 24 hour care and support to meet his considerable needs. Over a period of time, his physical condition deteriorated and on or about 5 June 2014 he suffered a choking episode when eating a meal. He was admitted to hospital and underwent a procedure to remove an airway obstruction which apparently turned out to be a sprout. His care co-ordinator then requested a SALT swallowing assessment to be undertaken, which resulted in specialist advice that he required a soft diet with supervision during and for 30 minutes following a meal. Advice was also given about the oral ingestion of a number of medication tablets that he was required to take, which needed to be consumed individually with some lubrication. His care plan was altered to specifically record the SALT assessment and recommended regime of supervision and management. Over the autumn of 2014, his mental health condition deteriorated and his psychiatrist was in the process of reviewing and altering his medication, as he was suffering from persistent low mood. He had a history of imbalance and falls. He required supervision and assistance with all day to day activities, and in particular his personal hygiene. He suffered no further episodes of choking during this period. On 1 December 2014, he had a dizzy episode and fell to the floor in the shower whilst being supervised. He was admitted to Manchester Royal Infirmary and was seen and assessed originally in the Acute Medical Unit. It was unclear if he had been accompanied to hospital by a carer, but there is no evidence that his detailed care plan accompanied him, and no specific information was provided to the hospital about any particular condition or management in the community. The investigations ruled out any major emergency pathology, but there was evidence that he was suffering from an infection and he was started on antibiotics. He was then transferred to Ward 46. He was initially moved there on 3 December by one of the junior doctors and his condition appeared to be stable and his Early Warning Scores were 0.

	On 4 December he was reviewed by a Consultant Physician, who formed the clinical opinion that he was suffering from both a urinary tract and chest infection and his antibiotics were altered. Thereafter his condition remained stable, and gradually improved. Over the next few days the markers for infection reduced, and by 10 December he was considered to be fit enough to be discharged back into the community. At approximately 1230hrs, he was given an egg mayonnaise sandwich, which had to be taken out of its wrapper by a member of staff, and he was left to eat this unsupervised. About 15 minutes later, he was found in a slumped position on the table with evidence of cyanosis. The emergency buzzer was pulled and immediately the nurse and a junior doctor attempted to begin CPR and remove some food debris from the mouth pending the arrival of the crash team. They arrived very shortly thereafter and further food debris was removed from his upper airways/throat area. Unfortunately their attempts at resuscitation proved unsuccessful and he was pronounced deceased shortly before 1300hrs. A subsequent post mortem examination established that he died as a result of an acute aspiration of food. It was apparent from the evidence received by the court that he lacked mental capacity, but was not subject to a DoLS authorisation in the community, nor indeed was it even considered or applied for whilst in hospital. Prior to 10 December 2014, during his last admission, he did not apparently demonstrate any difficulties with consuming food orally. Nor was it noted or recognised that he actually lacked mental capacity. Had the hospital been aware of his SALT assessment, they would have adopted that aspect of his care plan and arranged for a further SALT assessment. His care co-ordinator was aware of his admission but presumed that his carers would have supplied a copy of his care plan or details of his SALT assessment. She did not contact the hospital direct or his carers to check this. She was not contacted by the hospital nor his carers to check any aspect of his medical history. His carers did not provide the hospital with a copy of his care plan, and in particular details of his SALT assessment. Nor did the hospital communicate with either his GP, his care co-ordinator or his carers to request any information.
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: 1. Although it is appreciated that the events in question occurred later in 2014 following the Cheshire West case, it is a matter of concern that in the community, no formal mental capacity assessment was undertaken and no consideration of a DoLS authorisation was undertaken. 2. Consequently, upon his admission to hospital, it was not recognised that he lacked mental capacity. There was no formal assessment and he was treated as an ordinary patient. 3. Details of his mental health condition and in particular his care plan did not accompany him and/or were not supplied by his carers or his care co-ordinator to the hospital, but nor did the hospital check or request information from those looking after him in the community. The concern is that in this case, the deceased's death was avoidable and had there been appropriate communication between all those looking after him, steps would have been taken to ensure his oral diet complied with his current SALT assessment pending a review. It is suggested that the Hospital Trust, the Mental Health Trust and any caring organisation (whether that be a charity or a private organisation) should have policies and protocols which are applied to ensure that up to date information is provided upon admission to or discharge from hospital.
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. 1. It is suggested that the Hospital Trust, the Mental Health Trust and any caring organisation (whether that be a charity or a private organisation) should have policies and protocols which are applied to ensure that up to date information about patients' particular conditions (both mental and physical) are supplied between those caring for the patient when they are admitted to hospital when they are admitted, and back into the community when they are discharged. 2. It is suggested that in practice on admission to hospital and appropriate review of a patient's records and care plan should trigger a mental capacity assessment and an application for DoLS authorisation if appropriate.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30 September 2016. 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 Interested Persons. I have also sent it to organisations 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	**28 July 2016**