REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Rt. Hon. Matt Hancock, Secretary of State for Health and Social Care.
1	CORONER I am Chris Morris, Area Coroner for 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 3rd December 2019, Christopher Briggs, Assistant Coroner, opened an inquest into the death of Ailsa Stewart who died on 1st May 2019 aged 62 years. The investigation concluded at the end of the inquest which I heard between 6th and 9th April 2021. A post mortem examination undertaken by Dr [redacted], Consultant Pathologist on the Home Office Register, determined that Ms Stewart died as a consequence of: 1.a) Sepsis; due to 1.b) Pneumonia, pyelonephritis, limb ischaemia, pressure ulcers and epithelial damage due to prolonged contact with urine. 2) Obesity, Type II Diabetes. By way of conclusion, I recorded that Ms Stewart died as a consequence of natural causes, contributed to by neglect.
4	CIRCUMSTANCES OF THE DEATH Ms Stewart was bed-bound as a consequence of obesity, and suffered with Type II diabetes. She lived alone and was essentially dependant on domiciliary carers for all care. On 16th April 2019, carers asked a GP to visit Ms Stewart as they were concerned she was unwell. Following an examination, the GP sent Ms Stewart to hospital for further assessment and possible treatment. As a consequence, Ms Stewart's care provider suspended her package having assumed she would be admitted to hospital without verifying this was the case. Ms Stewart was assessed in the Emergency Department and following tests, was not considered to be acutely unwell. On the Morning of 17th

	April 2019, she was deemed medically fit to return home and transport was arranged via the ambulance service on the basis that her care package remained in place. An ambulance crew left Ms Stewart in bed at her home on that day, understanding that carers would be arriving to attend to her shortly. On 29th April 2019, the same ambulance crew returned to Ms Stewart's home to transport her to a pre-arranged medical appointment whereupon they found her to be gravely ill in her bed. She was taken to hospital where she subsequently died. Because her care package had been suspended, Ms Stewart received no domiciliary care between 17th and 29th April 2019. This lack of care caused her death.
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. – The court heard evidence as to an extensive range of actions which local agencies have taken in response to Ms Stewart's death to try and reduce the risk of a similar set of circumstances occurring again. That said, it was clear from the evidence that in England, family members play an essential part in ensuring continuity of care is maintained by sharing information between different agencies, and facilitating the co-ordination of care provided to vulnerable patients, particularly in circumstances where unplanned hospital attendances are required. It is a matter of concern that no cohesive national framework or guidance exists across health and social care, to prescribe the circumstances in which a domiciliary care package can be suspended, or sets out specific rules as to the roles and responsibilities of particular agencies to convey information when a vulnerable patient is sent home from an urgent care setting without having formally been admitted.
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 the date of this report, namely by 10th 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 [redacted] who had previously been related to Ms Stewart by marriage. I also have sent a copy to [redacted] of the Medical Defence Union who represented the General Practitioner, [redacted] (in-house solicitor) who represented Stockport Metropolitan Borough Council, [redacted] of Browne Jacobson LLP who represented Stockport NHS Foundation Trust, and [redacted] of Weightmans LLP who represented North West Ambulance Service NHS Trust. 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: 15th April 2021 Signature: Chris Morris HM Area Coroner, Manchester South.