REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of Greater Manchester Mental Health NHS Foundation Trust (GMMH), Chief Executive of Bolton Council, Chief Executive of Royal Bolton Hospital and the Secretary of State for Health.
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 4th February 2019, I commenced an investigation into the death of Barry Wayne Preston. The investigation concluded on the 19th February 2020 and the conclusion was one of **Narrative: Died from natural causes contributed to by a catheter that was not replaced within the guidance time period and the recognised complications of a series of falls.** The medical cause of death was **1a) Bronchopneumonia; 1b) A combination of urosepsis on a background of catheterisation, congestive cardiac failure and small bowel obstruction; II) Traumatic brain injury**
4	CIRCUMSTANCES OF THE DEATH Barry Wayne Preston was under the care of mental health services from 1964, initially as an in-patient and from 1993 in the community. He was vulnerable and lived in supported accommodation. He had no family or friends to support him and was dependent on mental health services for

	support. Bolton Council had delegated statutory responsibility to Greater Manchester Mental Health. He fell at his supported accommodation and was admitted to Royal Bolton Hospital on 28th October 2018 with an acute subarachnoid fracture. He remained in the medical assessment ward and had a further fall with no further injury. There was no new assessment of capacity and no best interests meeting. On 10th November 2018, he was transferred to Laburnum Lodge. He fell on two occasions within 24 hours at Laburnum Lodge. In the second fall, he required readmission to hospital. He had sustained a further bleed to the brain from the fall. He was placed on a medical outlier ward until 22nd November 2018 when he was moved to a complex care ward. No best interests meeting was held and no overarching assessment was made of his needs. He lacked capacity. His notes were inaccurately written up to show a long-term catheter was in place. As a result his catheter was not replaced after 4 weeks. He was moved to Trafford General Hospital for neuro rehabilitation. On arrival, he was disorientated and lacked capacity. Trafford were told his catheter was a long-term catheter - it was not. On 23rd January 2019, he developed symptoms of urosepsis caused by catheterisation. His short-term catheter inserted on 4th November 2018 would have been due to be changed at the beginning of December after 4 weeks of use. There was no evidence it was changed until he showed signs of urosepsis. He continued to deteriorate despite antibiotics and developed bronchopneumonia. He was placed on end of life care and died at Trafford General Hospital on 2nd February 2019.
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 quality of the documentation was not always of a good standard and part of the reason why his catheter was incorrectly believed to be a long term catheter. 2. The inquest heard that he was kept on wards that were not suitable for him or his needs. The inquest was told that this was due to capacity and flow issues within the Royal Bolton Hospital.

	3. The inquest heard that he had a care coordinator in the community. However the care coordinator did not take a lead in ensuring he was being supported in the acute settings or that best interests meetings were taking place. There was a lack of understanding between agencies of roles and responsibilities under the integrated care model. 4. The inquest heard that whilst he was being treated in acute settings there was no coordination or ownership of his care. It was unclear as to who was making decisions and assessing suitability of placement. 5. The inquest was told that for a long period of time whilst in the care of the NHS there was not a clear understanding of his lack of capacity to make decisions about his care. Acquiescence by him was seen as him understanding and having capacity. 6. The inquest heard that whilst an in-patient he was served a pudding that was so hot that, while eating it unsupervised, he dropped it on himself and suffered a burn. The burn did not contribute to his death but did cause significant additional discomfort. 7. His placement at Laburnum Lodge was made without a clear understanding of his needs. He fell twice within 24 hours sustaining a further bleed to his brain and readmission to the acute hospital.
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 29 June 2020. 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. 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 OBE** **HM Senior Coroner** **04.05.2020**