REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The One Stockport Health and Care Board
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 16th March 2023 I commenced an investigation into the death of David Hall. The investigation concluded on the 2nd August 2023 and the conclusion was one of **Narrative: Died from the complications of poor swallow which developed whilst an inpatient where admission had been due to a shortage of a suitable community placement and discharge was delayed due to a shortage of a suitable social care placement.** The medical cause of death was **1a) Aspiration Pneumonia and COVID-19; II) Dementia**
4	CIRCUMSTANCES OF THE DEATH David Hall had dementia and was admitted to Stepping Hill Hospital as a consequence of there being no safe and suitable place for him to reside when his usual care arrangement could not continue. He was fit and ready for discharge and was awaiting a placement in a suitable care facility. Whilst in the acute hospital setting, he deteriorated rapidly. His nutritional requirements were not fully met and his swallow deteriorated, which led to further weight loss and ultimately to him developing aspiration pneumonia. Whilst an in-patient he contracted covid 19 which impacted his overall health further. He continued to deteriorate and died at Stepping Hill Hospital on 14th March 2023.

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 evidence that if a suitable emergency social care placement had been available then Mr Hall would not have been admitted to hospital. However, there was no alternative as one could not be found and he was unsafe in the community. His stay in the acute setting led to a rapid deterioration. He had to continue to stay in hospital because a suitable social care placement could not be found for him. The evidence was that had he been in a suitable social care setting his needs would have been met in a more appropriate way. The evidence was that these difficulties in finding a placement were as a result of issues in availability of social care within Stockport.
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 7th December 2023. 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 1) [redacted] on behalf of the Family and; 2) Stockport NHS Foundation Trust, 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**  **12.10.2023**