## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: The One Stockport Health and Care Board** |
| 1 | **CORONER**<br><br>I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 24th February 2023 I commenced an investigation into the death of Mark Anthony McKessy. The investigation concluded on the11th July 2023 and the conclusion was one of **Narrative: Died from the complications of decompensated alcoholic liver disease when agencies had not effectively shared information or recognised his needs until shortly before his death.** The medical cause of death was **1a) Multi-Organ Failure; 1b) Pneumonia on a background of Decompensated Alcoholic Liver Disease; and II) Malnutrition.** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mark Anthony McKessy had learning disabilities and care needs. He lived in the community. His regular and prolonged use of alcohol led to him developing alcoholic liver disease. He had limited capacity to understand the risks that this presented to him due to his learning disabilities. The significant threat his lifestyle and health issues posed to his life was not recognised by agencies. There was limited information sharing by agencies and no understanding of how his learning disability was impacting his health. As a consequence his health continued to deteriorate. He was admitted to Stepping Hill Hospital and was diagnosed with decompensated alcoholic liver disease. He deteriorated and died at Stepping Hill Hospital on 18th February 2023. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>The inquest heard evidence that he had significant leaning difficulties and his capacity was limited. He was known to agencies. Despite this the inquest heard evidence that steps to reduce the risks were not taken due to:<br><br>1. Poor communication/information sharing between agencies which meant that there was no coordination of care and no clear overview of his needs; and<br><br>2. A lack of recognition by agencies involved with him of his health issues and their inter relationship with his social care and learning disability needs including the extent to which he had capacity. This was compounded by limited Care Act assessments |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **4th December 2023**. I, the coroner, may extend the period.<br><br>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**<br><br>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; 2) Stockport Metropolitan Borough Council; and 3) Stockport NHS Foundation Trust , who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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**<br>**HM Senior Coroner**<br>  <br><br>**09.10.2023** |