REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Integrated Care
1	CORONER I am Alison Mutch, HM 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 29th September 2022 I commenced an investigation into the death of Terence Davenport. The investigation concluded on the 23rd August 2023 and the conclusion was one **of Narrative: Died from the complications of being pushed over by another resident at the care home where he resided when the risk presented by the other resident was not fully understood contributed to by his dementia and ischaemic heart disease.** The medical cause of death was **1a) Pneumonia on the background of the fractured left neck of femur (operated); II) Dementia (mixed type), ischaemic heart disease**
4	CIRCUMSTANCES OF THE DEATH Terence Davenport had dementia and lacked capacity. He was looked after at home by his wife. Following his admission to hospital he had to be placed urgently in a nursing home, as he was not safe to remain at home. A place was found for him at Kings Park Nursing Home. On 23rd May 2022 he was pushed by another resident who lacked capacity due to dementia. He fell as a consequence of the push and was admitted to the hospital where a fracture to the neck of femur was found. The other resident had a history of aggressive behaviour to others not known to the manager of Kings Park. On the balance of probabilities had that history been known the home would not have accepted that resident. Mr Davenport was operated on. Post-operatively he did not regain mobility and he declined nutritionally. This was probably as a consequence of the impact of the fall, fracture and operation on his cognition. He remained in an acute hospital setting after he was medically fit for discharge as a suitable care placement needed to be found for him. He continued to decline in the acute setting which was a difficult setting for him given his severe dementia. He was moved on to end of life care whilst awaiting discharge. He died at Tameside General Hospital on 24th September 2022.

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 inquest heard evidence that the acute hospital setting was difficult for Mr Davenport due to his dementia and created risks to his health once he was medically optimised. He had to remain there due to a lack of suitable care/nursing beds. This meant that he was in an unsuitable care setting and that a bed that could have been utilised for an acute patient was not available; 2. The inquest was told that resident who pushed Mr Davenport was not suitable for placement at the care home where the incident happened. The care home where previous incidents had occurred was out of area. The inquest was told that lack of information sharing between two GM local authorities, the care homes involved and GMP meant that the safeguarding issue was not recognised. It was unclear if this was due to an effective information sharing protocol not existing between local authorities/care homes/GMP in Greater Manchester or it not being adhered to. However, the impact was that the risk of harm was not understood, and staff and residents were put at risk.
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 12th 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; 2) Tameside Metropolitan Borough Council; 3) Kings Park Nursing Home; 4) Tameside General Hospital, 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**  **17.10.2023**