REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) Care Quality Commission** **2) Greater Manchester Integrated Care** **3) Secretary of State for Health and Social Care**
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 6th February 2024 I commenced an investigation into the death of George Neville COULTHARD. The investigation concluded on the 29th August 2024 and the conclusion was one of **Narrative: Died from natural causes contributed to by the complications of an accidental fall and the complications of necessary anticoagulation medication. The medical cause of death was 1a) Frailty; II) Chronic Kidney Disease, Atrial Fibrillation (anticoagulated), Fall leading to necrotic skin wounds, Gastrointestinal bleed.**
4	**CIRCUMSTANCES OF THE DEATH** George Neville Coulthard had an accidental fall and sustained wounds to his skin as a consequence. He was in significant pain and discomfort as a consequence and the wounds deteriorated. As a consequence of his increasing frailty he had a further fall and a long lie. He was admitted to Wythenshawe Hospital. His skin was treated proactively whilst he was an inpatient and slowly his wounds improved. Whilst an inpatient he had a series of gastrointestinal bleeds probably as a consequence of his anticoagulant medication. The bleeds and the intervention following the first bleed increased his overall frailty and reduced his physiological reserves further. On 18th December 2023 it was agreed he should be discharged to a care home given his deterioration and the fact he was unlikely to improve further. He was not discharged until 11th January due to there being no care home beds available for him. He was discharged on 11th January 2024 to Hilltop Hall Care Home. The basis of the discharge and expectations were not clear. He was then transferred to Bramhall Manor for rehabilitation which was not compatible with the assessment of 18h December. He continued to deteriorate and died at Bramhall Manor on 27th January 2024.
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. –

1. Mr Coulthard was assessed as being suitable for discharge on 18th December. He remained in an acute hospital setting for a further 4 weeks due to challenges in identifying a suitable care home. This was due the inquest was told to a shortage of suitable places and the Christmas period. The impact of this on Mr Coulthard was that he remained in an acute setting when the inquest was told the care he required would have been better delivered in a care home /nursing home setting.
   In addition the inquest heard evidence that it meant that an acute bed required for other patients was not available creating delays in allocating beds to patients requiring admission. The inquest was told that significant delays of this nature occur on a regular basis and are often exacerbated over the Christmas period.

2. The lack of effective communication between the discharging team and the community teams meant that it was not understood if Mr Coulthard was on End of Life Care or for rehabilitation. The staff at the first home treated him as an End of life patient / palliative care patient as a consequence even though the paperwork suggested he may be a discharge to assess patient. As a consequence he was moved to another care home for rehabilitation although the evidence was that there was little purpose in the transfer.

3. The inquest also heard evidence that the staff at the care home had queried what level and type of care was to be delivered to Mr Coulthard given his overall presentation. However there was no evidence that the management team had sought to clarify the position or ensure the internal documentation reflected the correct position.

4. The evidence before the inquest was that whilst in the community prior to his final hospital admission the access to information and support, from tissue viability and district nursing teams, to care for and treat his wounds was very limited. Better access to wound care would have reduced the risk of further wound deterioration in the community and reduced the risk of him requiring inpatient care for his wounds. However the demands across GM on TVN and DN services made this difficult to achieve.

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 19th November 2024. 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 Manchester University NHS Foundation Trust, [redacted] on behalf of the family, 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** **Senior Coroner**  **24/09/2024**