REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Downshaw Lodge 2) Care Quality Commission
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 25th January 2024 I commenced an investigation into the death of James Astley. The investigation concluded on the13th August 2024 and the conclusion was one of Narrative: Died from natural causes contributed to by dehydration and poor nutritional status. The medical cause of death was **1a) Urosepsis, vascular dementia II) Frailty, dehydration, poor nutritional status.**
4	CIRCUMSTANCES OF THE DEATH James Astley had dementia and was immobile. His nutritional status declined significantly from November 2023. In December his swallow deteriorated and led to him becoming increasingly frail. On 2nd January he was started on antibiotics. On 3rd January he was seen again by a GP and found to have deteriorated further. He was admitted to Tameside General Hospital where he was treated for urosepsis and dehydration. Despite treatment he continued to deteriorate due to his frailty. He died at Tameside General hospital on 22nd January 2024.
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 Mr Astley was at significant risk due to poor nutrition and fluid intake. However the MUST documentation was

	not correctly completed and the overall quality of fluid and nutrition charts was poor. As a consequence he became increasingly frail and the risk to his overall wellbeing and physiological reserves continued. 2. Overall documentation at the home was limited and lacked detail
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 5th 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 [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**  **10/09/2024**