REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) The Lakes Care Centre 2) Secretary of State for Health and Social Care 3) 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 6th February 2024 I commenced an investigation into the death of John Francis HOWLETT. The investigation concluded on the 13th August 2024 and the conclusion was one of Narrative: **Died from exacerbation of chronic obstructive pulmonary disease contributed to by frailty due to dehydration and poor nutritional status. The medical cause of death was 1a) Infective exacerbation of chronic obstructive pulmonary disease II) Frailty**
4	CIRCUMSTANCES OF THE DEATH John Francis Howlett had severe chronic obstructive pulmonary disease. He was placed at The Lakes Care Home due to his severe chronic obstructive pulmonary disease. He required oxygen and was bedbound. He became increasingly frail whilst at The Lakes with poor nutrition and fluid intake. He developed an infection and was admitted to Tameside General Hospital. He was treated but despite the treatment he continued to decline as a consequence of the exacerbation of his underlying chronic obstructive pulmonary disease and frailty. He died at Tameside General Hospital on 31st 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 that on arrival at A and E at Tameside Hospital Mr Howlett spent 22 hours in a corridor despite suffering from an infection and the distress that this caused. The inquest was told that this was due to the demands on the department and the challenges of moving patients onto wards due to capacity issues. The inquest was told that this was not unique to that particular day or indeed to the hospital and was the picture across the country at that time. 2. The evidence before the inquest indicated that the care home in question had been of concern in relation to the care offered to residents for some time. It was indicated that action plans were in place particularly in relation to safeguarding concerns given the vulnerability of residents. However despite those steps being in place and the concerns the systems were not in place at the care home to robustly monitor his nutritional status and fluid intake. He became increasingly frail with decreased physiological reserves as a consequence.
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 1st 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** **HM Senior Coroner**  **06/09/2024**