REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Secretary of State for The Department of Health and Social Care 2) Tameside Metropolitan Borough Council 3) Care Quality Commission
1	CORONER I am Alison Mutch, senior coroner, for the coroner area of Manchester South
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 26th June 2024 I commenced an investigation into the death of Bernard Lyon. The investigation concluded at the end of the inquest on 5th March 2025. The conclusion of the inquest was Narrative**: Died from the complications of aspiration pneumonia which developed as a consequence of aspiration of food whilst resident of a nursing home. The medical cause of death was 1a) Aspiration Pneumonia II) Dementia, Frailty, Myocardial Fibrosis and Cardiomegaly.**
4	CIRCUMSTANCES OF THE DEATH Bernard Lyon was placed on a modified diet as a consequence of his dysphagia. He moved to Hyde Nursing Home on 4th January 2024 as he needed full time care due to his needs. Unknown to his family Hyde Nursing Home was subject to a quality improvement action plan. It is probable his family would not have chosen the home had they known about the concerns of the quality improvement team. A multiagency meeting in December did not fully consider the risks presented by the audit of the home. As a consequence, the home was permitted to continue to accept new residents. It is probable that if the position had been fully discussed at the December meeting, the home would not have been permitted to accept new residents. Bernard Lyon would probably not have been resident. Whilst resident at Hyde Nursing Home, Bernard Lyon's modified diet care plan was not always adhered to by staff. This was due to a shortage of managers and communication issues between the management team and staff.

	On 22nd January he attended Tameside General Hospital. He was found to be very unwell with sepsis. There was a delay in giving antibiotics as a consequence of the volume of patients in the Emergency Department at the time. He was treated for aspiration pneumonia. He deteriorated despite active treatment and was placed on end-of-life care. On 30th January 2024 he died at Tameside General Hospital. A postmortem examination found he had microscopic traces of food in his lungs and that had probably led to him developing aspiration pneumonia.
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 could 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 care home in question was recognised as having too few managers for it to be effectively managed but was allowed to continue to operate and was seeking to expand 2. The home relied on agency staff who the inquest was told struggled to have sufficient grasp of the English language to understand instructions given and to communicate with residents. 3. The inquest was told that the Local Authority regularly held MAC meetings to look at care home issues from a multi-agency perspective. The CQC was invited but rarely attended the meetings. As a consequence, the flow of information to the CQC was reduced. 4. The inquest was told that there was no process to let a family know of concerns that agencies had about a care home or that it was subject to an improvement plan. This meant that families were being left to make decisions about where to place family members unaware of the actual situation and concerns. 5. The evidence given to the inquest indicated significant delays in the handover from the ambulance to the ED team. This was due to pressure on the ED but meant that ambulances were tied up for longer than necessary and then had a knock-on impact on the ability of the ambulance service to respond to calls. The inquest was told that TGH had made efforts to improve the turnaround time, and it was currently at just an average time of 23.22 minutes. There was further evidence that TGH were not unusual amongst hospitals in the Northwest with the turnaround time at other hospitals running at over 1 hour.

	6. The Emergency Department at TGH was extremely busy on the day Mr Lyon arrived which was not unusual. The sheer volume of patients who were seriously ill meant that there was a delay in him being given antibiotics in accordance with his need. The Trust had taken steps to address this, but it was accepted that where there was a significant demand on an ED compliance with the national sepsis guidance was far more difficult to achieve. 7. The inquest was told that the build-up of patients and levels of demand in the ED at TGH were not unusual and continued. As an illustration of the ongoing nature of the demand in recent months one patient has waited in ED for 3 days for a bed. The delay in transfer was due to an ongoing demand for beds and delayed discharges of patients medically optimised but with no suitable non acute/community provision being available.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 **4th June 2025**. 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: the partner of Mr Lyon's on behalf of the family, 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. They may send a copy of this report to any person who they believe 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**  **09/04/2025**