REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1)Manchester University NHS Foundation Trust 2)Greater Manchester Mental Health 3)Greater Manchester Integrated Care Board
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 5TH November2024 I commenced an investigation into the death of **Janet Alison Anderson**. The investigation concluded at the end of the inquest on 14th April 2025. The conclusion of the inquest was narrative: Died from the complications of Lewy Body Dementia and drug induced Parkinsonism contributed to by a prolonged hospital stay when her discharge was not progressed expeditiously. The medical cause of death was **1a) Bilateral pneumonia 1b) Generalised deterioration with reduced mobility and oropharyngeal dysphagia 1c) Lewy body dementia; and Parkinsonism secondary to antipsychotic treatment for schizophrenia; and II) Chronic kidney disease; Chronic obstructive pulmonary disease.**
4	CIRCUMSTANCES OF THE DEATH

	Janet Alison Anderson had schizophrenia and was on medication for it. She developed Parkinsonism symptoms as a consequence. She also had Lewy Body Dementia. She was under the care of Greater Manchester Mental Health for her mental health. She was admitted to Manchester Royal Infirmary for a suspected infection from a nursing home and was treated. She was exhibiting Parkinsonism symptoms that were attributed to still being on anti-psychotic medication. A decision was made to keep her on the medication by Greater Manchester Mental Health but was not documented and she was not seen by the team until September 2024. She was medically optimised for discharge from the end of May 2024. She remained in hospital because Greater Manchester Mental Health did not find a suitable discharge placement for her. She did not need to be in an acute setting. The treating clinicians felt the acute setting was detrimental to her health and the prolonged stay contributed to a decline in her health. She began to rapidly decline and had a series of infections that caused her to become increasingly frail. She died on 28th October 2024 at the Manchester Royal Infirmary from bilateral 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 inquest heard evidence that the prolonged hospital stay and lack of progress in finding a suitable place in the community significantly contributed to her decline. She had been suitable for discharge from 20th May and there was no clear strategy to progress her discharge or for the two different trusts to work together to ensure a speedy and safe discharge. The evidence before the inquest indicated a lack of joined up working between the two trusts that meant that despite the clinical concerns about the impact of her prolonged hospital stay she remained in an acute setting

	2. The GMMH documentation was of a poor quality and did not capture key discussions/decisions including in relation to medication. As a consequence, trust staff were not fully sighted on earlier decisions and her needs. 3. The lack of progress in discharge meant that an acute hospital bed was not available to other patients who needed care in an acute setting.
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 July 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: Mother of Ms Anderson 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. 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**  **09/05/2025**