REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Chief Executive Pennine Care NHS Foundation Trust, 225 Old Street, Ashton-Under-Lyne OL6 7SR **2.** Chief Constable Greater Manchester Police, Northampton Road, Manchester M40 5BP **3.** Chief Executive Oldham Borough Council, 130 Rochdale Road, Oldham OL1 2JA **4.** Chief Executive North West Ambulance Service, 399 Ghorley New Road, Bolton BL1 5DD
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION AND INQUEST** On the 8th May 2025 I commenced an investigation into the death of Masood Hamid. The Inquest concluded on the 5th August 2024. The medical cause of Mr Hamids death was ascertained following a Home Office Post-Mortem examination and recorded as: 1a. Heart Failure due to Ischaemic Heart Disease in the context of an inter-facility hospital transfer requiring the appropriate use of restraints. 2. Alzheimers and Vascular Dementia, Chronic Kidney Disease The conclusion of the Inquest was that the deceased died as a result of natural causes significantly contributed to by an inappropriate lengthy inter-facility hospital transfer.
4	**CIRCUMSTANCES** Mr Hamid died on the 24th December 2024 on the Rowan Ward at the Royal Oldham Hospital. He had been residing in Shawside Care Home, Oldham. He was 80 years old and also had physical health co-morbidities including heart failure, a history of acute Myocardial Infarction, Diabetes, Chronic Kidney Disease and epilepsy following a traumatic brain injury. On the 19th December 2024 a Mental Health Act assessment had taken place and he had been detained under Section 2 of the Mental Health Act 1983. He remained at Shawside Care Home until a bed was available. The reason for his detention was due to the challenging behaviour he was presenting with as a result of his Alzheimers and vascular dementia. On the 23rd December 2024 a bed became available on the Rowan Ward and transportation of Mr Hamid was arranged. The court heard this would have been arranged by the local authority Advanced Mental Health Practitioner (AMHP). Shawside had expressed a view that transfer during the day would have been preferable as Mr Hamid had a better relationship with day care staff. North West Ambulance Service (NWAS) arrived at Shawside Care Home at 21:12 hours. On arrival Mr Hamid was in his room, calm and sleepy.

	When paramedics attempted to conduct physical observations, he became agitated. This included "flailing his arms." As a result at 21:28 hours NWAS contact Greater Manchester Police (GMP) for assistance with the transportation. At 21:48 hours GMP reviewed the police log and a decision was taken that GMP would not attend such an incident. GMP closed their log at 22:37. t was unclear from the evidence as to whether this decision was communicated to NWAS. The evidence from NWAS was that they remained at Shawside awaiting police attendance.As the police log was closed it was placed into a queue whereupon closed logs were reviewed by another officer. At 23:45 a GMP officer reviewed the closed log and requested more information from NWAS. At this stage a decision was made for GMP to attend and assist, in line with the North West Regional Mental Capacity Act Joint Protocol 2023. GMP officers arrived at Shawside at 00:08 hours on the 24th December 2024. Due to the level of agitation Mr Hamid presented with he was appropriately restrained in handcuffs and also strapped into the ambulance bed. He remained agitated on the journey to the hospital. He was taken to Rowan Ward at the Royal Oldham Hospital where he was handed over to hospital staff at 00:38. Within a short time of arriving at hospital he once again became agitated when physical observations were attempted. He was on constant observations and was being observed by a Nursing Assistant. The period of time the Nursing Assistant was left alone conducting these observations was for an approximate 10 minute window. During this time Mr Hamid was initially agitated, the Nursing assistant turned off the lights and partially closed the door so as not to disturb other patients. Mr Hamid then then expressed a noise which was thought by the nursing assistant to be a snore. He was on the bed and was thought to be asleep. Within a very short period of time a Dr entered and noted he was unresponsive. As a DNACPR was in place no resuscitation was attempted and he was pronounced deceased.
53.	**CORONER'S CONCERNS** During the course of the investigation 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:- **Pennine Care NHS Foundation Trust and Oldham Borough Council** 1. There was a lack of planning or consideration between all those involved in his care as to the best time and the least distressing way in which Mr Hamid could be transported to the hospital. This in full knowledge that any move would likely cause distress to a patient with dementia and physical health issues. **Pennine Care NHS Foundation Trust** 2. There was an ineffective investigation into the death of a patient who died in the care of the state whilst detained under the Mental Health Act 1983. As a result, the findings in the SWARM huddle document contradicted evidence of key witnesses. A lack of effective investigation in such cases means there is ineffective learning in order to prevent future deaths. **GMP and NWAS** 3. There was ineffective communication between GMP and NWAS between 21:28 hours and 23:45 which delayed the deployment of officers to assist NWAS staff with the transportation of the deceased. This delay meant a prolonged period of distress and agitation which contributed to the stress placed on the deceased.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and 1 believe each of you respectively 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 15 October 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 namely:- The family of Mr Hamid Pennine Care NHS Foundation Trust Greater Manchester Police 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 from. 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	Date: 20/08/2025 Signed:'

MATTHEW COX
ASSISTANT CORONER
ON BEHALF OF
JOANNE KEARSLEY