REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Care Quality Commission** **Acer Mews Care Home**
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 1st August 2025 I commenced an investigation into the death of Alan Paul PEET. The investigation concluded at the end of the inquest on 20Th November 2025. The conclusion of the inquest was narrative: Died from complications of quadriplegia. The medical cause of death was 1a Sepsis 1b Bronchopneumonia 1c Quadriplegia
4	**CIRCUMSTANCES OF THE DEATH** Alan Paul Peet became quadriplegic because of an accidental fall at his home address. He required a tracheostomy tube. He was discharged following a prolonged hospital stay and rehabilitation to Acer Mews Care Home. He was funded for one-to-one care due to his high level of need. On 26th July his condition deteriorated at the care home. Clear and full observations were not recorded on a regular basis during the course of the afternoon, so it is not clear the rate at which he was deteriorating. An ambulance was called on 26th July 2025 he was taken to Tameside General Hospital. He was found to be septic possibly because of bronchopneumonia on arrival and to have a NEWS 2 score

	of 8. He was treated but deteriorated rapidly and died at Tameside General Hospital on 28th July 2025.
5	**CORONER'S CONCERNS** 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. – Mr Peet according to the evidence heard at the inquest was placed at Acer Mews Care Home. His care according to information from his family was provided at a cost of approximately £10,000 a week. This was because he required 24/7 one to one care in a nursing home setting because of the extent of his needs including management of his tracheostomy tube. The inquest heard that at the home there were 2 units, with one registered nurse allocated to each unit. The remainder of the staff were Health Care Assistants. On the day of his admission to hospital the nurse trained in tracheostomy management decided not to cover the unit Mr Peet was in even though there were 3 patients requiring support with tracheostomies on that unit. Instead, they chose to work on the other unit. This left a nurse untrained in tracheostomies on that unit. It was unclear why there was no management oversight of this decision and what steps were in place at the time to avoid such a situation arising. The inquest was also told that the agency nurse used on the day did not have log in rights to the electronic systems in place at the home including the medication system. It was indicated that the manager at the time was aware of this and that it was likely that the nurse could as a consequence only make entries under the details of the other nurse. During the course of the inquest, it was difficult to unpick who had made certain entries. Even though Mr Peet was on one-to-one care and those involved could have no other residents to write up during the time they were caring for him the overall quality of the notes was extremely poor. Entries were limited and it was impossible to fully understand from the notes what had been observed and what had happened and at what point.

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 Friday 30th 2026. 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 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	**5th December 2025** [redacted] **HM Senior Coroner Alison Mutch**