Lancashire & Blackburn with Darwen Coroners

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (pursuant to Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. NHS England
1.	**Coroner** I am Kate Bisset, Area Coroner for Lancashire and Blackburn with Darwen.
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 the 8th of November 2022 the Coroner's Office was notified of the death of John Graham Alston and an investigation commenced into his death. There was an initial delay whilst Police and the CQC considered whether a criminal prosecution was required but confirmation of no criminal changes and thus a reversion to a Coronial investigation resumed on the 13th June 2024. An inquest was opened and adjourned on the 28th of February 2023 and a final inquest took place between the 2nd and 5th of December 2025. The conclusion of the inquest was that: "John Graham ALSTON, who was better known as Graham ALSTON, died on the 8th of November 2022 at the St Catherine's Hospice, Lostock Hall, Preston as a consequence of injuries he sustained after he was punched to the face on the 2nd November 2022. Mr ALSTON was a resident at a specialist dementia care home due to a diagnosis of dementia. Whilst at that home, he was punched to the face by another resident who was significantly younger than Mr ALSTON

	and had impaired cognition. The other resident had been inappropriately placed at the care home, in part due to incomplete assessment documents being shared with the home via an unsuitable discharge pathway. Concerns were quickly raised regarding the suitability of the resident's stay at the home but a new placement was not able to be identified. On the 2nd November 2022, at least three staff members were with the resident when Mr ALSTON entered the communal space and touched the resident who responded with violence towards Mr ALSTON. None of the staff members observed Mr ALSTON enter the room or approach the resident and so no staff member prevented the incident from occurring. It was known that the resident presented a risk of violence to other residents and had used violence against Mr ALSTON in the past."
4.	**Circumstances of the death** Mr Alston was a 70 year old man who had a diagnosis of dementia which sometimes resulted in challenging behaviours. By early 2020 he was resident in a challenging behaviours unit of a residential care home to support his needs. In August of 2022 another resident, [redacted], moved into the home. He was a much younger male with an acquired brain injury and he displayed significant aggression against staff, residents and on a number of occasions, Mr Alston himself. The care home quickly identified that the placement was not suitable but no alternative placement was identified. There were delays in commencing a search for an alternative placement due to confusion about which commission area had responsibility for [redacted]. On the 2nd of November 2022, [redacted] entered a dining room with his 1:1 carer. At least two other members of staff were present in the dining room. Mr Alston entered the dining room, unwitnessed by staff, approach and took hold of [redacted] as he often held hands with others. [redacted] reacted by punching Mr Alston twice causing a bleeding nose. Staff intervened to separate the men and Mr Alston was assessed. He was initially believed to be not seriously hurt but later demonstrated neurological symptoms and had a seizure. He was taken to hospital where investigations revealed he had an unsurvivable brain bleed. Mr Alston was transferred to a hospice where he died on the 8th of November 2022.
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 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. [redacted] had been moved to the Lancashire ICB commissioning area by a Bolton (Greater Manchester) commissioning service due to the existence of care home with a place for him (care home one). His placement at that care home broke down and he was taken to the local accident and emergency department. [redacted] remained in hospital for some time and was then discharged to care home two where the circumstances resulted in Mr Alston's death occurred. It was quickly apparent that care home two could not meet [redacted] needs and this was escalated to the Lancashire ICB. However the care home had first been directed to the Bolton (Greater Manchester) authorities by the local hospital. There was confusion as to which ICB was the commissioning body. This resulted in work being carried out by Lancashire ICB which ought to have been completed by the Bolton (Greater Manchester) ICB and a delay in commencing a search for an alternative and safe placement for [redacted] There were also difficulties in sharing information for discharge processes because it was unclear which area or from where [redacted] had come. This inquest concluded that due to the complexity of [redacted] presentation, the delays due to confusion about ICB identification did not contribute to Mr Alston's death occurring at the time at which it did. However, I am concerned that there may be other cases where inaccurate or unknown information about which commissioning service is responsible for a resident can result in delays to accessing increased funding for support, services or more suitable placements. I am concerned that these delays may result in future deaths and that a clearer system is necessary to identify at an early stage and appropriately communicate that to a home who accepts a resident. I am concerned that determination of funding ICB arises on a reactive basis when additional care or changes are required and thus the time taken to resolve the issue delays necessary care or changes when proactive determination of the issue before problems arise ought to be possible.
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 the 30th of January 2026. I, the Coroner, may extend the period and to take into account the likely disruption to services caused by Christmas breaks, I extend that period of response to the 14th of February 2026 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 Family of Mr Graham Alston; The Family of [redacted]; The Hulton House Care Home Lancashire ICB Greater Manchester ICB Lancashire Teaching Hospitals Trust The Department of Health and Social Care 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. She may send a copy of this report to any person who she 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.	**05.12.2025** [redacted] **Kate Bisset** **Area Coroner for Lancashire and Blackburn with Darwen**