REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Heywood Health 2. Advocacy Together 3. Pennine Care NHS Foundation Trust 4. Rochdale Adult Care
1	**CORONER** I am Catherine McKenna, Area 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 7 December 2018, I commenced an investigation into the death of Hazel Maureen Lewis. The inquest concluded on 4 November 2019. The medical cause of death is 1a) metastatic cancer of the breast 2) left fractured neck of femur (conservative management). The Conclusion was 'Natural Causes to which an injury sustained as a result of an unwitnessed fall contributed.'
4	**CIRCUMSTANCES OF DEATH** Hazel Lewis had learning and communication difficulties and a long history of declining medical investigations and social support. In January 2016, she was noted to have a lump suggestive of breast cancer and declined investigations. She was deemed to have the requisite mental capacity to decline investigations at that time. On 30 May 2017, Ms Lewis's long-term partner died. Her package of social care support was increased and whilst initially resistant, Ms Lewis was able to fully engage with the care package and carers. She was referred to her GP in relation to the breast lump. On 10 July 2017, the GP undertook a home visit jointly with a Care Act Advocate. Ms Lewis was assessed as lacking capacity to make decisions in relation to investigations into the breast lump. A best interest decision was made by the GP not to proceed with investigations, prior to consultation with the social worker or community learning disabilities nurse. When the social worker and community learning disabilities nurse were spoken to about the best interest decision, neither of them appreciated that they were being consulted for the purpose of best interest decision-making. Options as to whether it might be possible to encourage Ms Lewis to engage with medical investigations were not explored. Ms Lewis had no family or friends to consult with and an Independent Mental Capacity Act Advocate was not formally instructed as part of the best interest decision-making process. On 14 November 2018, Ms Lewis was found on the floor at her home address by carers. She had sustained a hip fracture as a result of an unwitnessed fall. She was taken to the Royal Oldham Hospital where she was managed conservatively and died at 16:14 hours on 28 November 2018. Whilst the hip fracture significantly contributed to her death, the cause of death was metastatic cancer of the breast.

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:- **For all recipients** Whilst evidence was given that all witnesses had undergone mandatory Mental Capacity Act 2005 (MCA) training, the Court was left with some concerns about the adequacy of that training as it relates to decisions concerning life-sustaining treatment. It would appear that those involved in the Deceased's care did not fully understand the order in which steps are to be taken under the MCA, the nature of consultation and the role of consultees, when an IMCA is to be instructed and the need to explore all available options before a best interest decision is reached. The best interest decision not to proceed with investigations in this case was taken prior to consultation with those involved in the Deceased's care. Neither the social worker or community learning disability nurse appreciated that they were being consulted when spoken to by the GP. The carers who provided daily care to the Deceased and who had been able to foster her engagement with social care were not consulted. An IMCA was not formally instructed. There was no exploration of or advice given in relation to the options available to support the Deceased in engaging with medical investigations or medical care such as desensitisation or 1:1 care. The community learning disability nurse's understanding was that the Deceased had the capacity to decline investigations. A best interest meeting was not convened and whilst this was not mandatory under these circumstances, it would have afforded an opportunity to ensure that agencies applied their minds to the possibility that the Deceased may engage with investigations if additional support was offered. It would also have facilitated more effective communication between the agencies and on-going management of the consequences of the best interest decision. **For Advocacy Together** The statutory advocate involved in the Deceased's care was acting as a Care Act Advocate rather than an IMCA. I heard evidence that in order for the advocate to act as an IMCA, a separate referral to Advocacy Together would be required. Both the GP and social worker had understood that the advocate involved in the Deceased's case was acting as an IMCA. There is a need for greater clarity as to which role an advocate is acting so that all agencies involved in the care of individuals lacking capacity can ensure that the requirements of the MCA are complied with.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I 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 **6 January 2020**. 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:- [redacted] I have also sent a copy of my report to Greater Manchester LeDeR steering group who may find it 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 from. He may send a copy of this report to any person who he believes may find it usefulor 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: 6 November 2019 Signed: