Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 **South Staffordshire & Shropshire NHS Foundation Trust……**
2 **Hampshire Hospitals NHS Foundation Trust ……**
3 **……**

1 CORONER

I am Grahame Antony SHORT, Senior Coroner for the area of SOUTHAMPTON AND NEW FOREST

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 02/11/2017 00:00 I commenced an investigation into the death of Nigel Philip MALLOY aged 56. The investigation concluded at the end of the inquest on 05 June 2018. The conclusion of the inquest was:

I a Traumatic Head Injury

I b Fall

I c

II

4 CIRCUMSTANCES OF THE DEATH

At about 10.00 on 29 October 2017 whilst alone Nigel Malloy fell from a second floor window at 33 Southgate Street Winchester as a result of which he struck his head on the ground below and suffered severe injuries. I was unable to determine whether this was deliberate or accidental but accepted that he was intoxicated with alcohol at the time. He died in Southampton General Hospital two days later.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: The Deceased was alcohol dependant and suffered depressive symptoms. On 22 May 2017 he fell from a window in circumstances very similar to those on 29 October 2017 and on that occasion suffered head injuries and was taken to Southampton General Hospital. After this fall he was regularly drinking excess alcohol leading to multiple admissions to the Emergency Department at Royal Hampshire County Hospital Winchester operated by Hampshire Hospitals NHS Foundation Trust (HHFT), but was then discharged once sober without any follow up. On 22 September 2017 he referred himself to the Inclusion Service provided by South Staffordshire & Shropshire NHS Foundation Trust (SSSFT) and started to receive some assistance. On 16 October 2017 the deceased sustained a fall in the street and was taken to Winchester hospital for treatment of his head wound but discharged the same day. There was no sharing of information between the Alcohol Liaison service provided by HHFT and the Inclusion Service provided by SSSFT or coordinated plan to treat his alcohol dependence.

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 14 September 2018. 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:
[redacted]

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. 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

Grahame Antony SHORT
Senior Coroner for
SOUTHAMPTON AND NEW FOREST
Dated: 19 July 2018