REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Mr[redacted] Chief Executive Officer, Borough Care, 9 Acorn Business Park, Heaton Lane, Stockport SK4 1AS
1	CORONER I am Chris Morris, Area Coroner for Greater 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 22nd October 2019, I opened an inquest into the death of Peter William Howarth who died at Stepping Hill Hospital, Stockport on 10th October 2019 aged 83 years. The investigation concluded with the inquest which I heard on 7th July 2020. The court heard evidence that Mr Howarth died as a consequence of:- **1 a) Cardiac failure;** **b) Cerebrovascular disease;** **II Dementia, frequent falls, rib fractures, fractured neck of femur (operated).** The inquest concluded with a narrative conclusion to the effect that **Mr Howarth died as a consequence of natural causes contributed to by consequences of injuries sustained in a number of falls.**
4	CIRCUMSTANCES OF THE DEATH Mr Howarth, who had a complex medical history, was admitted to hospital on 9th October 2019 having sustained injuries in a fall at Brynhaven Rest Home in Stockport. Whilst in hospital, Mr Howarth had another fall, as a consequence of which he suffered a fractured neck of femur which required surgery. Mr Howarth died in hospital as a consequence of complex underlying health problems combined with injuries sustained in a number of falls.

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. The court heard evidence that, despite the fact Mr Howarth was injured in a fall at his care home which led to his final admission to hospital, Borough Care has not undertaken any investigation into the circumstances of that fall. Robust investigations into falls in care and nursing homes are essential with a view to considering whether or not there is any learning to be derived from the incident for the benefit of other residents with a view to reducing the risk of death arising from falls in similar circumstances.
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 3rd November 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 Mrs [redacted] as the family's legal representative, in addition to Ms [redacted] of Browne Jacobson LLP who acted on behalf of Stockport NHS Foundation Trust. I am also under a duty to send the Chief Coroner a copy of your response. The report will be copied to the Care Quality Commission and Stockport Metropolitan Borough Council, who may find it useful or of interest. 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	**Christopher Morris** **HM Area Coroner** **08.09.2020**