REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of Tameside and Glossop Integrated Care NHS Foundation Trust
1	CORONER I am Christopher Briggs, Assistant Coroner, for the Coroner Area of 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 (Investigation) Rules 2013.
3	INVESTIGATION and INQUEST On 10th November 2022 an investigation was commenced into the death of Roger Southwick. The investigation concluded at the end of the inquest on 10th March 2023. The conclusion of the inquest was that the medical cause of death was: **1a) Subdural Haemorrhage; 1b) Accidental Fall; II) Myocardial infarction, Lower respiratory tract infection, anticoagulation medication** My conclusion was that this was an **accidental death**.
4	CIRCUMSTANCES OF THE DEATH Roger Southwick had a stent inserted in his chest following a heart attack in October 2022. On 5th November 2022 he was feeling breathless and admitted to Tameside General Hospital where a chest infection was diagnosed and low sodium levels detected secondary to his heart failure and he was admitted for treatment. A falls risk assessment was inaccurately completed and concerns raised about his mobility were not actioned. On 7th November Roger was found outside his cubicle having fallen and hit his head. CT scanning revealed a significant subdural haemorrhage which was not amenable to surgical intervention and he died at Tameside General Hospital on 9th 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 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. – (1) There was a failure to complete the Falls Risk Assessment accurately; (2) There was a failure to reassess the risk of falls when staff were informed by members of the deceased's family of his significantly compromised mobility and unsteadiness on his feet; (3) The Investigation Report prepared by the Trust failed to identify and therefore did not address issues 1 and 2 above.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisastion) 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 11th July 2023. I, the Coroner, may extend this 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 1) Mr Southwick's Family; 2) Care Quality Commission, who may find it useful or 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 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 Briggs** **HM Assistant Coroner**  **16.05.2023**