REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of Stockport Metropolitan Borough Council** **2. Chief Executive of Stockport Homes**
1	**CORONER** I am Lauren Costello, Assistant Coroner, for the Coroner area of South Manchester
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 5th July 2023 an investigation was commenced into the death of Ian Dixon, then aged 72 years. The investigation concluded at the end of the inquest on 13th December 2023. At the end of the Inquest, I recorded a narrative conclusion that Mr Dixon died as a result of traumatic brain injury following a fall on a background of chronic alcohol excess with cerebellar atrophy. The medical cause of death being: **1a) Traumatic Head Injury** **1b) Chronic Alcohol Excess with Cerebellar Atrophy**
4	**CIRCUMSTANCES OF THE DEATH** Ian Dixon was a recovering alcoholic and had a history of falls. He had been suffering from confusion, was unsteady on his feet and was awaiting a memory assessment. Following an assessment by an Adult Social Care duty worker on 31st May 2023, a decision was made to expedite the installation of an additional handrail on his staircase to try to minimise the risk of falls. Prior to that meeting Mr Dixon had hurt his left arm and hand, and the additional rail would mean that he could hold it with his undamaged hand to stabilise himself on the stairs. The installation was to be completed through Stockport Homes and the expectation was that this would be completed within 3 days in accordance with the timeframe for an urgent request. On 8th June 2023, Mr Dixon was found deceased following a fall at the bottom of the stairs in his home. The fall caused an extensive skull fracture with an acute right sided subdural hematoma. A post-mortem examination showed chronic cerebellar atrophy, due to chronic alcohol excess which likely caused his confusion and ataxia, leading to falls. A police investigation confirmed that there was no evidence of suspicious circumstances or third-party involvement. At the time of his death no handrail had been installed. The inquest heard that there is no process in place for the council to be notified when requested work is completed or if there are any delays in work completion. The Inquest also heard that the work had been marked as complete on the Stockport Homes system even though the handrail had not been fitted.

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 **MATTER OF CONCERN** is as follows. – (1) The Inquest heard that there is no policy in place governing the interaction between Stockport Metropolitan Borough Council and Stockport Homes following a request for the installation of equipment. This means that there is no review undertaken to check whether urgent equipment has been installed, urgent repairs completed or if there are delays/issues with the works requested.
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 14th May 2024. 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], on behalf of the Family. 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	**Lauren Costello** **HM Assistant Coroner** L. Costello **19.03.2024**