REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) The Department of Health and Social Care** **2) Greater Manchester Integrated Care**
1	**CORONER** I am, 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** On16th January 2025 I commenced an investigation into the death of Doreen Swann. The investigation concluded on the 5th June 2025 and the conclusion was one of **Narrative:** Died from the complications of a fall when not being cared for in compliance with her risk assessment**.** The medical cause of death was **1a) Traumatic brain injury 1b) Fall II) Advanced dementia, frailty, E. coli septicaemia, bronchopneumonia.**
4	**CIRCUMSTANCES OF THE DEATH** Doreen Swann was a patient at Tameside General Hospital who had been medically optimised and was awaiting discharged when she developed a further infection. She was a high falls risk. She fell whilst unobserved and when the bed rails were up when they should not have been. She suffered a traumatic brain injury and died at Tameside General Hospital on 13th January 2025.
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 inquest heard evidence that Doreen Swann was only in hospital at the point of her fall because her discharge had been delayed due to a shortage of a suitable social care placement. The evidence was that nursing/caring for high falls risk patients in an acute setting is challenging and resource intensive. 2. The evidence given to the inquest was that this delayed discharge and the ongoing risk it presents was not an isolated incident at TGH -as an example the evidence given was that there were regularly 30 plus patients with a

	delayed discharge over 3 weeks due to a lack of social care beds .The evidence indicated that this challenge was not unique to Tameside. 3. The evidence indicated that managing a falls risk and the consequential risk to life is better managed outside an acute setting once the clinical need for a hospital stay has passed. 4. Delayed discharges such as Doreen Swann's reduces the availability of beds for other patients and creates a knock-on impact across the hospital particularly in relation to the Emergency Department.
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 **4th September 2025**. 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 the family and Tameside General Hospital, 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	**Alison Mutch** **HMC Senior Coroner**  **10/07/2025**