REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Secretary of State for Health and Social Care

CORONER

I am Chris Morris, Area Coroner for Greater Manchester (South).

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

INVESTIGATION and INQUEST

On 20th March 2025, Alison Mutch OBE, Senior Coroner for Manchester South opened an inquest into the death of Leslie Thompson who died at Tameside General Hospital, Ashton-under-Lyne on 20th February 2025, aged 94 years. The investigation concluded with an inquest which I heard on 16th July 2025.

The inquest determined Mr Thompson died as a consequence of:

1a) Traumatic acute on chronic subdural haematoma

II) Dementia, Frailty of old age, Anticoagulated Atrial Fibrillation, Heart failure

At the end of the inquest, I recorded a conclusion of Accident

CIRCUMSTANCES OF THE DEATH

Mr Thompson died on 20th February 2025 at Tameside General Hospital Ashton-under-Lyne as a consequence of a head injury sustained in a fall in hospital against a background of a chronic subdural haematoma and multiple complex health Problems

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.

Mr Thompson sustained the fall in hospital which ultimately led to his death at a point in time where he had been assessed as medically fit for discharge, but was awaiting a physiotherapy assessment.

At inquest, the court heard evidence that this hospital (in common with many others) does not have core physiotherapy services operating at evenings and weekends. I am concerned as to the effects of this in terms of delays to discharge, and the resultant exposure to risk of patients for whom an acute hospital environment is not most suitable.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **23rd 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, together with Mr Thompson's widow and the hospital's legal representative.

I have also sent a copy to the 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.

Dated: **29th July 2025**

Signature: Chris Morris, Area Coroner, Manchester South.