REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Lakes Care Centre
1	CORONER I am Alison Mutch, senior coroner, for the coroner area of 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.
3	INVESTIGATION and INQUEST On 3rd June 2025 I commenced an investigation into the death of Ronald PERRY . The investigation concluded at the end of the inquest on 31st October 2025. The conclusion of the inquest was narrative: **Died from frailty contributed to by the complications of a fall sustained at the care home where he resided. The medical cause of death was 1a) Frailty; and II Recurrent Pneumonia, Vascular Dementia, Fracture of Left Neck of Femur (operated on), Bilateral acute Subdural Haematomas.**
4	CIRCUMSTANCES OF THE DEATH Ronald Perry had become increasingly frail and was discharged from Tameside General Hospital to The Lakes Care Home on 12th March 2025. He was on anticoagulant medication. He had a series of falls following his admission to The Lakes. The first of these was on 14th March 2025. Following that fall, he then fell on 24th March 2025 and was taken to Tameside General Hospital and then discharged back to The Lakes. His family raised concerns about his falls risk. On 21st April he had a fall that was not escalated for medical advice and no additional fall risk assessments were carried out. He should have been escalated: On 25th April he had a further fall and was taken to Salford Royal Hospital via Tameside General Hospital. He had sustained a bleed to the brain and fractures including one to the neck of femur. He was operated on. He deteriorated and died at Salford Royal Hospital on 30th May 2025.

5	<u>CORONER'S CONCERNS</u> 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. During the course of the inquest it was difficult to be clear at times as to what care had been delivered or what steps had been taken because the documentation relating to care and risk was poor. 2. The falls risk assessment documentation was incomplete and did not appear to have been updated after falls had occurred. 3. The falls policy regarding the need to seek medical advice where a resident on anticoagulation had a fall that had been unwitnessed did not seem to be widely understood by staff or adhered to on all occasions.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 **9th January 2026**. 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 of Mr Perry, Tameside Metropolitan Borough Council and 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. They may send a copy of this report to any person who they believe 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 OBE** **Senior Coroner**  **14/11/2025**