REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **Northern Care Alliance** **Salford Royal Hospital** **Stott Lane** **Salford** **M6 8HD**
1	**CORONER** I am Joanne Kearsley, Senior Coroner for the coroner area of Greater Manchester North.
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 3[11] November 2025 I commenced an investigation into the death of Mr Barry Peter Joseph Davies. The Inquest concluded on the 28th May 2026. The conclusion of the Inquest was that Mr Davies died as a result of injuries sustained following an accidental fall.
4	**CIRCUMSTANCES OF THE DEATH** The brief circumstances are, on the 20th October 2025 Mr Davies fell whilst walking to his GP surgery. He was admitted to the Emergency Department of the Royal Oldham Hospital. A CT scan was undertaken which showed a bleed on his brain and he was admitted. On the 22nd October 2025 his condition deteriorated and a further CT scan undertaken on the 23rd October 2025 showed significant progression of the bleed. Following a discussion with the neurosurgical team he was not suitable for surgical intervention and he was placed on palliative care. He died on the 29th October 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 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) The Court heard Neurological observations were not carried out on Mr Davies as frequently as they should have been before his deterioration was noted. (2) The court heard evidence a Nurse had discontinued the Neurological observations on the evening of the 22nd October whilst Mr Davies was still waiting his second CT scan.

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 7 August 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 – the Family of Mr Davies 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	**12 June 2026** [redacted] **HM Senior Coroner Ms. Kearsley**