REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Anna Morris, Assistant Coroner, for the coroner area of Greater Manchester South
2.	**DATE OF REPORT** **18 June 2026**
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. Tameside General Hospital You are under a duty to respond to this report within 56 days of the date of this report, namely by **13 August 2026**. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

5.	**SUMMARY OF CORONER'S CONCERN** At the inquest into Mr. Smith's death, I heard evidence that his MUST score during his prior admission should have triggered the use of daily fluid and diet monitoring charts to ensure that Mr. Smith was obtaining enough nutrition. At the inquest, there was no evidence that these charts were ever used. Mr. Smith was also discharged without being seen by a dietician
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 2nd January 2026, I commenced an investigation into the death of Mr. Brian Smith aged 83 years. The investigation culminated in an inquest which was heard by me on the 12th June 2026. At the inquest I made the following findings – **The medical cause of death was** 1a) Sepsis 1b) Pseudomembranous Colitis II) Mesothelioma due to asbestosis, fractured left neck of femur sustained following a fall. **I recorded a narrative conclusion, which was that -** The deceased died in Tameside General Hospital on the 28th November 2025 from complications that developed from pseudomembranous colitis. I find that his overall physiological reserve was weakened by a fall and fractured neck of femur sustained on the 24th November 2025, against the background of his terminal cancer.
8.	**CIRCUMSTANCES OF DEATH** The deceased was 83 years old at the time of his death. He had a diagnosis of mesothelioma and was being treated palliatively. On the 24th November 2025 he was taken to Tameside General Hospital following an unwitnessed fall at home. He sustained a fractured left neck of femur and surgery was arranged. However, on the 26th November the deceased's condition deteriorated. An abdominal CT scan indicated ischaemic colitis in the bowel, and he was started on antibiotics for suspected sepsis. Despite appropriate treatment, his condition continued to deteriorate, and he died in hospital on the 28th November 2025. Postmortem examination and histology confirmed the presence of pseudomembranous colitis.

	Prior to his admission on the 24th November, he had a recent prior admission to Tameside General Hospital between the 4th-6th November 2026, where he was treated for urosepsis. It was recognised on this admission that Mr. Smith's oral intake and diet were both poor and his MUST score was 3 out of 6. He was discharged from hospital without being seen by a dietician.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: Prior to his admission on the 24th November, he had a recent prior admission to Tameside General Hospital between the 4th-6th November 2026, where he was treated for urosepsis. It was recognised on this admission that Mr. Smith's oral intake and diet were both poor and his MUST (Malnutrition Universal Screening Tool) score was 3 out of 6. I heard evidence that this MUST score should have triggered the use of daily fluid and diet monitoring charts to ensure that Mr. Smith was obtaining enough nutrition. At the inquest, there was no evidence that these charts were ever used. Mr. Smith was also discharged without being seen by a dietician. I am concerned that a patient who should have had his diet closely monitored and did not and that if this practice continues there is a risk that future deaths could occur unless action is taken
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. The family of Mr. Brian Smith I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the

	report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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