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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br>**THIS REPORT IS BEING SENT TO:**<br>1. Pennine Acute Hospitals NHS Trust<br>2. Department of Health |
| 1 | **CORONER**<br>I am Matthew Cox, Assistant Coroner for the Coroner area of Manchester North |
| 2 | **CORONER'S LEGAL POWERS**<br>I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 |
| 3 | **INVESTIGATION and INQUEST**<br>On the 12th February 2015 Catherine McKenna, Assistant Coroner, commenced an investigation into the death of Toni Piel. The investigation was concluded at the end of the Inquest on the 26th May 2015. The conclusion of the Inquest was that the deceased died on the 23rd December 2014 at his home address, 65 Wood Park Court, Whitebank Road, Limeside, Oldham as a result of a head injury caused by a fall. The evidence did not disclose whether a head injury which occurred on 10 December 2014 and which resulted in treatment at The Royal Oldham Hospital or a separate unconnected injury caused his death, the medical cause of death being:<br>1a) Intracranial Haemorrhage<br>1b) Head Injury<br>1c) Fall |
| 4 | **CIRCUMSTANCES OF DEATH**<br>The deceased was born on 5th March 1949 and was 65 years old at the time of his death on 23rd December 2014.<br>On the 10th December 2014 the deceased suffered an injury to the back of his head in a fall at his home address. He was taken to the Royal Oldham Hospital by emergency ambulance. The ambulance records outline a possible recurrent fall with the fourth fall that day. The deceased stated that he had had approximately 4 cans of lager.<br>On arrival in the emergency department it was noted that the deceased had a laceration to the back of his head approximately 5 inches, that he drank most days and that there was the possibility of recurrent falls.<br>The injury was cleaned and closed with 4 sutures. The deceased was considered to be safe to be discharged home with head injury advice and wound care.<br>On the 23rd December 2014 one of the deceased's neighbours contacted the police as he was unable to make contact with the deceased. Entry to the deceased's flat was forced and the deceased's body was found lying on the floor by the bed fully clothed.<br>A Post Mortem Examination was conducted by [redacted] Consultant Histopathologist. He noted a large subdural haematoma in the middle and posterior regions of the brain and a prominent subarachnoid haemorrhage in both temporal lobes and cerebellum. He said the evidence was consistent with another injury suffered at The Royal Oldham Hospital 10 December 2014. In his opinion the possible explanations were that the fall which resulted in treatment at The Royal Oldham Hospital on 10 December 2014 had |

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| | triggered a further fall which had led to his death or that he had suffered a fall which was not connected with the fall for which treatment was provided on 10 December 2014. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:-<br><br>i) At the time the deceased was discharged home following the head injury on 10 December 2014 the deceased's home circumstances were apparently not taken into account. Had such an assessment been made it would have been noted that there was no-one able to observe the deceased at home. The NICE clinical guideline 175 issued January 2014 recommends that this should be taken into account.<br><br>ii) No assessment of the risk factors in discharging the deceased was documented in the deceased's records. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>**In my opinion action should be taken to prevent future deaths and I believe each of you respectively have the power to take such action.** |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely 3rd September 2015. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely:-<br><br>[redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary from. 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 | Date: 9th July 2015 Signed: |