REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Borough Care Ltd., 9, Acorn Business Park, Stockport SK4 1AS**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 21st December 2015 I commenced an investigation into the death of Malcolm Bennett dob 20th January 1931. The investigation concluded on the 13th June 2016 and the conclusion was one of **Open Conclusion**. The medical cause of death was 1a Head Injury.
4	**CIRCUMSTANCES OF THE DEATH** **The deceased was resident in a Care establishment and whilst there he sustained a number of injuries due to falls and he also became involved in a number of fracas with other residents again sustaining injury.** **During the late hours of the 15th December 2015 he was allegedly assaulted by a female resident, he was injured but was not taken to hospital until the early hours of the following day.** **Later that same day, he died at Stepping Hill Hospital as a result of a head injury. There was insufficient evidence to show whether the head injury which led to his death emanated from the alleged assault or from one or more of the falls to which he was prone.**
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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – **In the care Plan for this person, it clearly indicated that in the event of any significant injury he should be taken as expeditiously as possible to the Emergency Dept. of the hospital. Clearly this was not done, in that the staff left him knowing that he had apparently been hit by someone and he might well be injured, and they did not call for an ambulance for another three hours. In the light of his cause of death, this delay might have been contributory.**
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 **17 August 2016**. 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 [redacted] (son of the deceased). I have also sent it to **CQC** 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.
9	**22.6.16** **John Pollard, HM Senior Coroner**