REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of Tameside General Hospital, Registered Manager of Sunnyside Care Centre.
1	CORONER I am Alison Mutch ,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 5TH June 2017 I commenced an investigation into the death of Margaret Ellen Postill .The investigation concluded on the 20th October 2017 and the conclusion was one of accidental death. The medical cause of death was 1a Bilateral subdural hematoma; 1b fall; and 2 old age, dementia.
4	Margaret Ellen Postill had dementia and was a resident at Sunnyside Care Home. On 2nd May 2017 she fell at the care home. She was taken to Tameside General Hospital where tests showed that she had not suffered any fractures or bleed to the brain. She was discharged back to the care home. She arrived back at about 2:55pm on 2nd May 2017. She mobilised to a limited degree and ate her tea. At 6:25pm she was found, having fallen on the corridor. She went to Tameside General Hospital again. No CT was carried out initially and she was considered suitable for discharge. She then had a series of seizures. A CT scan showed a subdural hematoma caused by the 2nd fall. She deteriorated over the next few weeks and was moved to palliative care. She died on 31st May 2017 at Stamford Unit.
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 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. – 1. There did not appear to have been any evaluation of Mrs Postill after her return on 2nd May 2017. In particular no evaluation/assessment sheets were completed.(Home) 2. The documentation held by Tameside Hospital relating to the second visit was of poor quality .In particular there was a lack of detail around the decision making.(TGH)
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 15th February 2018. 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] daughter of the deceased, 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	Alison Mutch OBE HM Senior Coroner 21/12/2017