REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health, Mayor of Greater Manchester, GM Health and Social Care Partnership
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 6th June 2019 I commenced an investigation into the death of Charles Williamson. The investigation concluded on the 25th September 2019 and the conclusion was one of **Accidental death.** The medical cause of death was **1a) Urinary tract infection on a background of catheterisation;1b) Traumatic brain injury; and 2) Hospital acquired pneumonia**
4	CIRCUMSTANCES OF THE DEATH Charles Williamson fell in Portugal suffering a significant traumatic brain injury. He was repatriated to England and admitted to Wythenshawe Hospital. A scan identified an enlargement of the chronic subdural haematoma. A drainage operation was performed at Salford Royal Hospital. He was moved back to Wythenshawe subsequently. A scan on 16th February 2019 showed a recurrence of the chronic subdural haematoma. A further successful drainage procedure was undertaken at Salford Royal Hospital. He was subsequently again returned to Wythenshawe Hospital. On 18th March 2019 further tests concluded with a MR scan showing a likely infection in the brain. He was transferred to Salford Royal Hospital for a

	craniotomy. He was on antibiotics for 6 weeks initially at Salford Royal Hospital and then at Wythenshawe. He was transferred to the neuro-rehabilitation unit at Trafford on 17th April 2019 he continued to deteriorate with confusion and loss of mobility. He was catheterised as a consequence. He showed signs of an infection which was a urinary tract infection and a pneumonia. He was treated with antibiotics. He continued to decline and died at Tameside General Hospital on 5th June 2019.
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. – The inquest heard that following neurological incidents such as those sustained by Mr Williamson it will often be the case that a key to returning to baseline or closer to baseline is effective and early neuro-rehabilitation. The inquest was told that a shortage of appropriate neuro-rehabilitation beds in Greater Manchester was in some cases preventing early effective neuro-rehabilitation and increasing the risk of complications which could lead to death.
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 25th November 2019. 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] on behalf of the family, 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** **30.09.2019**