**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO: The Minister of State for Social Care, Greater Manchester Health and Social Care Partnership |
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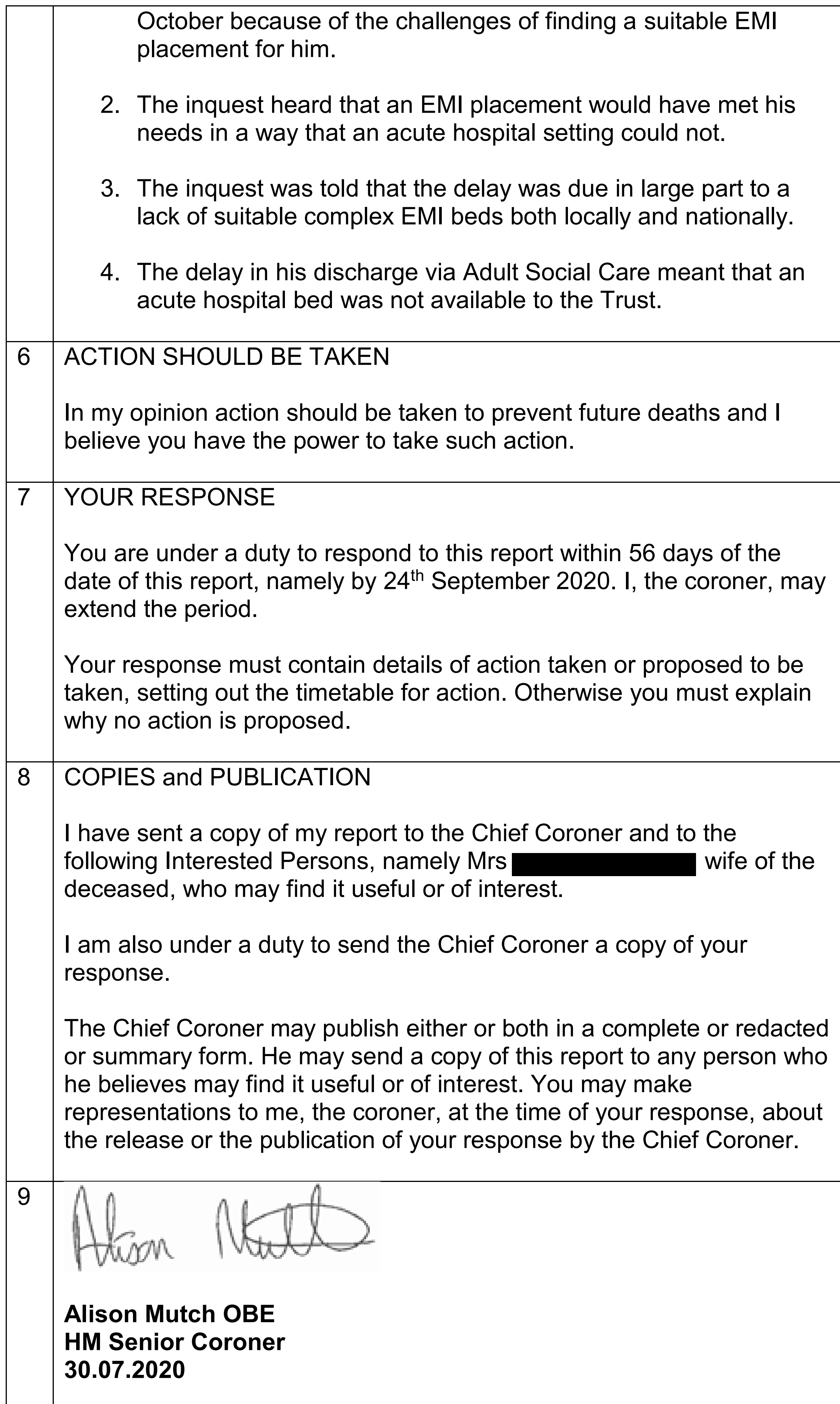
| 1 | CORONER<br><br>I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South |
| 2 | CORONER'S LEGAL POWERS<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 |
| 3 | INVESTIGATION and INQUEST<br><br>On 25th October 2019 I commenced an investigation into the death of Reginald Collins. The investigation concluded on the 10th July 2020 and the conclusion was one of **Accidental Death**.<br><br>The medical cause of death was **1a) Aspiration pneumonia on a background of immobility; 1b) Fracture neck of femur following a fall; and II) Ischaemic heart disease, Frailty** |
| 4 | CIRCUMSTANCES OF THE DEATH<br><br>Reginald Collins fell and fractured his neck of femur at The Meadows (Saffron Ward). He was admitted to Stepping Hill Hospital on 13th September and on 14th September he was operated on. He was medically optimised by 19th September 2019. Discharge was delayed due to a suitable placement not being available due to his complex needs. He developed aspiration pneumonia and deteriorated and died at Stepping Hill Hospital on 22nd October 2019. |
| 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>1. The inquest heard that Mr Collins could have been discharged from 19th September when he was medically optimised. However he remained in an acute hospital setting until his death on 22nd |



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| | October because of the challenges of finding a suitable EMI placement for him.<br><br>2. The inquest heard that an EMI placement would have met his needs in a way that an acute hospital setting could not.<br><br>3. The inquest was told that the delay was due in large part to a lack of suitable complex EMI beds both locally and nationally.<br><br>4. The delay in his discharge via Adult Social Care meant that an acute hospital bed was not available to the Trust. |
| 6 | ACTION SHOULD BE TAKEN<br><br>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<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th September 2020. 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 Mrs wife of the deceased, who may find it useful or of interest.<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 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**<br>**HM Senior Coroner**<br>**30.07.2020** |