REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Tameside Clinical Commissioning Group, Secretary of State of Health & NHS England**
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 20th November 2020 I commenced an investigation into the death of Stanislaw Wieslaw ZIELINSKI. The investigation concluded on the 2nd June 2021 and the conclusion was one of Narrative: Died from a pulmonary embolism following hospitalisation and an operation for complications of a fall which occurred whilst suffering from insomnia and anxiety. The medical cause of death was 1a Cardiac arrest; 1b Pulmonary Embolism II fall from window on 20/10/2020 - subdural haematoma, multiple vertebral and rib fractures, prolonged immobilisation.
4	**CIRCUMSTANCES OF THE DEATH** Stanislaw Wieslaw Zielinski reported symptoms of anxiety and insomnia to his GP from June 2020. He was not seen face to face but via telephone appointments. His mental health continued to deteriorate. His GP believed a referral had been made to mental health services. They did not have a record of receiving it. It was unclear why that referral was lost in the system. He self-referred to Healthy Minds and was triaged on 1st October. He was not written to until 15th October offering a telephone assessment. An appointment was made for 21st October 2020. He was prescribed mirtazapine, zopiclone and diazepam by the GP to address his anxiety and insomnia. They appeared to have little impact on him. His insomnia and anxiety increased. On 20th October 2020 in the early hours of the morning, he fell from an upstairs window. He told his wife that he believed he was being chased and fell from the window. He was taken to Salford Royal Hospital where he was found to have suffered multiple rib and vertebrae fractures and a subdural haematoma. He was operated on for the spinal fractures. On 18th November 2020 he was transferred to Tameside General Hospital. In the early hours of the 19th November 2020, he had a significant cardiac arrest due to a pulmonary embolism and died on 19th November 2020 at Tameside General Hospital.
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 due to Covid 19 and the restrictions and challenges that this

	presented to the health services the way in which care was delivered to Mr Zielinski was significantly impacted. In particular: 1. Pre Covid Mr Zielinski would have been seen face to face rather than through a series of telephone consultations. The inquest heard that he and his family struggled to communicate with the GP to explain his deteriorating health position as a result of how his GP practice was delivering health care. The inquest heard evidence that as a consequence his deteriorating picture was not fully understood by his GP and he was additional anxious as a result of an inability to express his concerns in person. 2. Mental health services were experiencing delays due to operating under the constraints of Covid and staffing issues. As a result there was a delay in offering him support which would have assisted him. The inquest heard that the existing challenges pre Covid for mental health services had been exacerbated by Covid due to an increased need for their services in part as a result of the impact on mental health of isolation during lockdown.
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 19th October 2021. 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] (family of 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	**24th August 2021**  **Alison Mutch** **HM Senior Coroner Greater Manchester South**