REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Home Instead Senior Care (High Peak)** **The Stables, 48B Buxton Road, High Lane, New Mills, Stockport, SK6 8BH**
1	**CORONER** I am Joanne Kearsley, Area 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 26th March I commenced an investigation into the death of Mary Hallworth date of birth 17.09.1915. The investigation concluded on the 18th July 2014 and the conclusion was one of Accidental Death. The medical cause of death was 1a) Bronchopneumonia 1b) Fractured left hip and II) Asthma and Hypertension.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances leading to the death of the deceased are as follows:- The deceased was a frail, elderly lady who was living at her home address. She was practically immobile and required assistance with all her daily needs. She was prone to falls from her bed. On the 18th March 2014 at 08.25am the deceased was found by a carer on the floor of her bedroom. She was complaining of pain on her left side. The carer sought assistance from the office as she was not medically trained. Following advice the carer left Mrs Hallworth when a family friend was contacted and arrived at the property. She was then lifted 'in a fireman's lift' and placed on the bed. She was still in pain and was given liquid paracetamol.
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. – - Despite the deceased being in pain and having fallen, no medical attention was sought or considered for a period of 24 hours.
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 6 January 2015. 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] 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	**Date: 11 November 2014** **Joanne Kearsley, HM Area Coroner Manchester South**