REGULATION 28 REPORT TO PREVENT FUTURE DEATHS Rose Mary Hollingworth (Died 04/01/2022)

	THIS REPORT IS BEING SENT TO: 1. **HomeDotCare Limited,** Unit 11, Studios Holloway, Hornsey Street, London, N7 8GR 2. **Islington Social Services, London Borough of Islington** 222 Upper St, London N1 1XR 3. **Care Quality Commission,** 2 Redman Place Stratford London, E20 1JQ
1	**CORONER** I am JONATHAN STEVENS, Assistant Coroner, for the coroner area of Inner North London.
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 14th April 2022 Assistant Coroner Jonathan Stevens commenced an investigation into the death of ROSE MARY HOLLINGWORTH [age 83]. The investigation concluded at the end of the inquest on 26th July 2023. The conclusion of the inquest was of death by natural causes.
4	**CIRCUMSTANCES OF THE DEATH** ROSE HOLLINGWORTH was a frail lady with significant co-morbidites but was able to live in her own home because of package of care provided by HomeDotCare Limited, commissioned by Islington Social Services (London Borough of Islington). In the morning of 3rd January 2022, a carer employed by HomeDotCare Limited came to ROSE HOLLINGWORTH'S home as part of the package of care but upon finding ROSE HOLLINGWORTH apparently asleep left the property (after discussing the situation with the staff at HomeDotCare on the phone) without carrying out any welfare checks or providing any care.

The carer returned to ROSE HOLLINGWORTH'S home later the same day and only then, when finding ROSE HOLLINGWORTH still in bed, did she undertake welfare checks and found ROSE HOLLINGWORTH to be unresponsive, breathing noisily and covered in vomit/haematemesis.

An ambulance was called and ROSE HOLLINGWORTH was admitted to Whittington Hospital where she died the following day, namely 4th January 2022.

The medical cause of death was established at the inquest to be:

1 (a) spontaneous intra-cerebral haemorrhage

2 Hypertension, Ischaemic Heart Disease, Chronic Obstructive Pulmonary Disease, frailty.

The inquest heard evidence from [redacted], Consultant in Acute Medicine and General Internal Medicine at Whittington Hospital that ROSE HOLLINGWORTH had suffered a spontaneous catastrophic and un-survivable bleed and at no time would any medical intervention have been able to reverse that. Accordingly, even if the carer had carried out proper welfare checks when she came in the morning, and raised the alarm, it would not have affected the outcome in the case and ROSE HOLLINGWORTH would still have died.

At the inquest the following findings were made:

(i) There were significant failings in the care give to ROSE HOLLINGWORTH. In particular:

a. The carer should have conducted a proper welfare check on her first care visit.
b. The carer should have been concerned that ROSE HOLLINGWORTH was not up and waiting for the arrival of the carer as she would normally have been.
c. The carer should have checked ROSE HOLLINGWORTH'S catheter bag, which was found later found to have 1-2 days of urine.
d. The carer should have made sure that ROSE HOLLINGWORTH took her medication.
e. The carer should not have been told by HomeDotCare when she called to leave ROSE HOLLINGWORTH and return at lunchtime.
f. The carer should have provided basic first aid at the scene.

(ii) The failings demonstrated a poor standard of care which in other circumstances could have delayed potentially lifesaving intervention and treatment.

	(iii) The carer assigned on the 3rd of January 2022 was a Somali speaking carer who required a Somali translator in order for her to give evidence at the inquest, raising concerns that the carer lacked the ability to properly and safely communicate with ROSE HOLLINGWORTH in English when attending to her care needs.
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 could 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 was a failure to provide suitably trained, experienced and competent carers for a vulnerable person dependent on a package of care. (2) There was a failure to properly supervise and manage the carers. (3) The Care & Support plan was not properly completed and contained significant errors. (4) There was a failure to properly monitor, review, manage and check the performance of the care agency.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation has 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 3rd May 2024. 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 Parties, [redacted] nephew of the deceased and [redacted] Niece of the deceased. 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	**8th March 2024** **SIGNED**